

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR			REG. NO. 79-06980									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
FRANKLIN THOMAS BAER, SR						3 30 79			2 15		P M	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		MONTH DAY YEAR		73		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U. S. A.				Frederick MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Frederick			Frederick Memorial Hospital			Owner & Operator			Plumbing & Heat			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland			Frederick		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		113 Water Street			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			
FIRST MIDDLE LAST			FIRST MIDDLE LAST			17. INFORMANT			ADDRESS			
William Baer			LILLIE MAE Baer			Mrs. Mary Baer, 113 Water St, Frederick, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Loud Hematemesis</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stress Ulcer</u> (c) <u>Cerebral Thrombosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Enlarged liver (possible secondary), Myocardial Ischemia</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 78</u> , to <u>March 30 79</u> , that (I) (we) lost saw the deceased alive on <u>March 30 79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22a. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
<u>Armenis</u>									3/30/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
ABDUL MAJEED			4 E CHURCH ST FRED. MD 2701									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial			April 2, 1979		Resthaven Mem. Gardens		Frederick Frederick Md.					
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Smith, Padeley, Keeney & Basford Funeral Home			APR 6 1979			<u>Armenis</u>						
106 East Church Street, Frederick, Maryland												

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR 115 ME (51))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 79-06981			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLEN ALLEN BEALE												2a. DATE KNOWN OF DEATH MONTH DAY YEAR 3 11 79		7b. HOUR OF ESTI- MATED DEATH MATED 3 11 79	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12-22-64		6. AGE (IN YEARS) LAST BIRTHDAY 14 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 11 79		2d. HOUR OF ESTI- MATED DEATH MATED 3 11 79		7d. HOUR OF ESTI- MATED DEATH MATED 3 11 79				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH FREDERICK MD.								
10. CITY OR TOWN OF DEATH Jefferson		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Horine Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT			12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Md.		13b. COUNTY Frederick		13c. CITY OR TOWN BRUNSWICK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 110 "A" ST.							
14. FATHER'S NAME FIRST MIDDLE LAST Kenneth N. BEALE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIRGINIA M. CHADWELL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT FATHER		ADDRESS BRUNSWICK, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a) and (b). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 5:30 P.M. 3 11 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) Car - Passenger									
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Hiway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Horine Rd Frederick Md									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Robert J. Thomas				TITLE (SPECIFY) Deputy				DATE SIGNED 3-11-79							
EXAMINER'S NAME (TYPE OR PRINT) Robert J. Thomas, M.D.				ADDRESS 812 Toll House Ave. Frederick, Md. 21701											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/15/79		23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE Lovettsville Loudoun VA.							
24. FUNERAL DIRECTOR NAME Feete Funeral Home				ADDRESS BRUNSWICK, Md.				25a. DATE REC'D. BY REGISTRAR MAR 15 1979		25b. REGISTRAR'S SIGNATURE Robert J. Thomas					

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James P. Thompson  
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James P. Thompson

James P. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-06982	
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BEST FAY FAY S. BEST</b>				2a DATE OF DEATH MONTH DAY YEAR <b>3 2 79</b>			2b HOUR <b>1<sup>00</sup> P M</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 27, 1899</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County MD.</b>					
10 CITY OR TOWN OF DEATH <b>Braddock Heights</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Vindobono Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Postal Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Postal Ser.</b>			
13a. STATE <b>Virginia</b>				13b. COUNTY <b>Loudoun</b>		13c. CITY OR TOWN <b>Purcellville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>"0" Street</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Shelly Solliday</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Verna Fields</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>224-60-5624</b>		17 INFORMANT ADDRESS <b>Route 1 - Box H43 L. Preston Bell Purcellville, Va. 22132</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>486- PNEUMONIA</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <b>2/28</b> , 19 <b>79</b> , to <b>3/2</b> , 19 <b>79</b> , that (1) (we) lost <b>2/28</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>W. J. Allgood</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/2/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WAYNE ALLGOOD</b>				22e. ADDRESS <b>BRUNSWICK, MD. 21716</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>03/4/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillsboro Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hillsboro Loudoun Va.</b>					
24. FUNERAL DIRECTOR <b>Ralph A. Snapp</b>				P.O. Box 896 <b>Purcellville, Va 22132</b>		25a. DATE RECEIVED BY FUNERAL DIRECTOR <b>MAR 6 1979</b>		25b. DECEASED'S SIGNATURE <b>Ralph A. Snapp</b>			

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DHMH - 16 50M 77/77  
(VR A 15(4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-06983

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
I. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		March 6, 1979	
Lizzie A. BISER						6:45 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Fe Male	White	Oct. 5, 1888		90 years		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.			Frederick County, MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Frederick	263 Dill Avenue, Frederick		Homemaker		Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS			
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Martin C. Coblenz		FIRST MIDDLE LAST Ellen Frances Brandenburg					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
no		none		216-46-7599 Richard C. Biser, Sr., Route 4, Frederick, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Vext. File.</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-Sclerotic C.V. disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 + yrs.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 + yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , 19 <u>79</u> , to <u>6 MARCH</u> 19 <u>79</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>6 MARCH</u> 19 <u>79</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>not</del> ) view the body after death.		22b. SIGNATURE <u>Charles H. Conley, Jr. M.D.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7 MARCH 1979</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Dr. Charles H. Conley, Jr., M.D.		Professional Buidling, Frederick, Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Mar 9, 1979		Reformed Cemetery		Middletown, Frederick, Md.	
24. FUNERAL DIRECTOR <u>Richard C. Biser</u> Smith, Fadelley, Keeney, Bassford Funeral Home 10 6 East Church Street, Frederick, Md. 21701				25a. DATE REC'D BY REGISTRAR <u>MAR 12 1979</u> 25b. REGISTRAR'S SIGNATURE <u>Harvey McCurdy</u>			

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-06984	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
METTIE MARCELLA BOLLER			March 14, 1979						9 a.m.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Caucasian		Feb. 25, 1897		82		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Frederick, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Frederick		Frederick Nursing Center				Homemaker		None			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland			Frederick		Thurmont		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		East Main Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			ADDRESS					
Alonza Williar			Jennie ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
No			XXXXXXXXXX		217-18-8942D Mr. Kenneth G. Finneyfrock, Sr. Thurmont, Md.						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>										3 mins	
4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD</u>										104vs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION						
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>4/1/79</u> to <u>4/1/79</u> , that (I) (we) last saw the deceased alive on <u>4/1/79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
<u>T.F. Hickey</u>			M.D.						3/15/1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
T.F. Hickey, M.D.			Parkview Medical Center Frederick, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Burial			3-17-1979		Weller Un. Meth. Cem.			Thurmont, Frederick, Maryland			
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Robert E. Dailey & Son			MAR 19 1979			<u>Robert E. Dailey</u>					
1201 N. Market Street			Frederick, Md. 21701								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | REG. NO. 79-06985  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Theresa   |  |  | FIRST MIDDLE<br>M M M  |   | LAST<br>BONEBRAKE  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 29-79                                   |   |  | 2b. HOUR<br>XXXXXXX 6:30 P M   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 8 1888  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90   |  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Illinois   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 13b. CITY OR TOWN<br>Frederick   |  | 13c. CITY OR TOWN<br>Mt. Airy   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>23 Old Annapolis Road                            |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Morris   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>Grace Hill  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>none  |  | 17. INFORMANT<br>George Bonebrake-son-(same as 13e)   |  |   |  | ADDRESS   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140 Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) Cerebral Vascular accident<br>(c) Arteriosclerotic Heart disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |   |  |  |  |
| 22. I certify that (I) <del>XXXXX</del> attended the deceased from March 10, 1979, to March 29, 1979, that (I) <del>xx</del> lost saw the deceased alive on Mar. 29, 1979, and that in (my) <del>xx</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) (did not) view the body after death.                  |  |  |  |   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br>Morris A. Wilkinson MD  |  |  |  |   |  | DEGREE  |  | 22b. DATE SIGNED<br>29 March 79   |  | 22c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Morris A. Wilkinson MD   |  |  |  |   |  | 22e. ADDRESS<br>702 N. Market St Fred Md  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>Apr. 2-79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln                             |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood Pr. Georges Md. |  |  |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.<br>8434 Ga. Ave., S.S. Md.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 4 1979   |  |   | 25b. REGISTRAR'S SIGNATURE<br>R. J. Kelly  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | REG. NO. 79-06986 |  |
|--|--|---|--|---|--|---|--|--|--|-------------------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  |                   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>James William Bowen  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 3 79  |  | 2b. HOUR<br>3 <sup>30</sup> AM   |  |                   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept. 13, 1904   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.  |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick Co. MD.                                       |  |  |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Wallpaper hanger               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |                   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Frederick  |  | 13c. CITY OR TOWN<br>Mt. Airy   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>Route 3, Box 202  |  |                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ferris - Bowen  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ollie May Phebus |   |  |  |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>218-32-4800   |  | 17. INFORMANT ADDRESS<br>Dorothy E. Bowen, Item 13  |  |   |  |  |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>4166<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Cor Pulmonale</u><br>(c) <u>Due to, or as a consequence of</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 mos.<br>2 yrs. |  |   |  |   |  |   |  |  |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AS WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                   |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>2/18/79</u> to <u>3/3/79</u> , that (1) we lost <u>2</u> above, (1) we (did) did not view the body after death.  |  |   |  |   |  |   |  |  |  |                   |  |
| 22b. SIGNATURE<br><u>Robert L. Kaufmann, M.D.</u>  |  | 22c. DATE SIGNED<br>3/3/79  |  |   |  | 22d. ADDRESS<br>804 Toll House Ave., Frederick, Md.   |  |  |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Mar. 6, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Pleasant Hill   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Monrovia, Frederick, Md.                             |  |  |  |                   |  |
| 24. FUNERAL DIRECTOR NAME<br>Olin L. Molesworth, Damascus, Md.   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 7 1979   |  |  |  |                   |  |



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FOR  
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REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-06987  
REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kenneth Ray Brandenburg</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>12</b> YEAR <b>1979</b> |   |  | 2b. HOUR<br><b>10 30</b> M  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cau.</b>  |  | 5. DATE OF BIRTH<br>Feb. <b>7</b> , DA <b>1934</b> YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>45</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Frederick Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Painter</b>                        |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Contractor</b>   |  |   |  |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland Frederick Myersville</b> |  |   |  |   |  |   |  |
| 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |  | 13c. STREET ADDRESS<br><b>Main St.</b>  |  |   |  |   |  |
| 14. FATHER'S NAME<br><b>Charles A. Brandenburg</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br><b>Pearl E. Hooper</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-30-5584</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Shirley Brandenburg Myersville, Md.</b>  |  |   |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerotic Heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>30 min</b><br><b>3 year +</b> |  |
|---|--|---|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 1</b> , 19 <b>73</b> , to <b>March 12</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>March 12</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Henry V. Chase M.D.</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Mar. 13, 1979</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Henry V. Chase M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>804 Toll House Ave Frederick MD</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>3/15/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>United Methodist</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Myersville Frederick Md.</b>   |  |

|  |  |                                   |  |   |  |  |  |
|--|--|-----------------------------------|--|---|--|--|--|
| 24. FUNERAL DIRECTOR'S NAME<br><b>Blake Funeral Home</b> |  | ADDRESS<br><b>Myersville, Md.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1979</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Bandy</b> |  |
|--|--|-----------------------------------|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

58280-25

MAILED 10 1975



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-06988

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>ERMA Lane Davis</b>   |  | 2a. DATE OF DEATH MONTH <b>3</b> DAY <b>12</b> YEAR <b>79</b>                   |  | 2b. HOUR <b>2:50</b> P. M.   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH <b>July</b> DAY <b>27</b> YEAR <b>1905</b>                          |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS   |  | 7. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick, MD.</b>                      |  | 8. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                      |  | 10. CITY OR TOWN OF DEATH <b>Frederick</b>   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Western Elec.</b>                                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>                        |  | 13b. COUNTY <b>Frederick</b>  |  | 13c. CITY OR TOWN <b>Frederick</b>   |  |
| 14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>Edward</b> LAST <b>Harman</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>E.</b> LAST <b>Haines</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                |  |
| 16b. SOCIAL SECURITY NO. <b>216-03-5754-A</b>   |  | 17. INFORMANT ADDRESS <b>George S. Harman, Union Bridge, Md.</b>                |  |  |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Upper gastro-intestinal bleeding</b><br><b>5301</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Esophagitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **1) Cirrhosis - prob alcoholic 2) Wernicke's encephalopathy 3) Pneumonia**

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>William O. Miller, MD.</b>  |  |   |  | DEGREE  |  | 22c. DATE SIGNED <b>3/12/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William O. Miller, MD.</b>   |  |   |  | 22e. ADDRESS <b>148 Thomas Johnson Dr. Frederick, Md.</b>                         |  |   |  |

|   |  |                                 |  |   |  |  |  |
|---|--|---------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                     |  | 23b. DATE <b>March 15, 1979</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lut. Church</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Taneytown Fred. Md.</b> |  |
| 24. FUNERAL DIRECTOR NAME <b>G. Douglas Stauffer</b> ADDRESS <b>Rt. 10 Box 66 Fred. Md.</b> |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1979</b>              |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

88280-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The [redacted] retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the coroner, it should be detached for use as the burial-transit permit.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical ~~examiner~~ must be notified ~~at once~~.

## MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-06989

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Grace Lenora DEW</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 3, 1979</b>   |  | 2b. HOUR<br><b>11:15 P</b>  |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 3, 1897</b>  |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 7b. IF UNDER 24 HRS<br>HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montevue Home</b> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD</b>  |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laundress</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Laundry</b>   |  |   |   |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN <b>Frederick</b>  |  |   |  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ephraim Biddinger</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine M. Unknown</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-16-0732</b>  |  | 17. INFORMANT<br><b>Eva L. Weasner,</b> ADDRESS<br><b>437 Lafayette Street<br/>Newtown, Pa. 18940</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Vertebral Artery Thrombosis</b><br><b>4332</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Generalized arterio-sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1978</b> , to <b>March 3, 1979</b> , that (I) <del>was</del> <b>was</b> saw the deceased alive on <b>March 3, 1979</b> , and that in (my) <del>own</del> <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <b>was</b> did not view the body after death.                   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Bernard O. Thomas Jr. MD</b> DEGREE   |  |   |  | 22c. DATE SIGNED<br><b>3/6/79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Bernard O. Thomas, Jr., M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>Professional Building, Frederick, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>March 6, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Frederick, Md.</b>   |  |   |  |   |   |
| 24. FUNERAL DIRECTOR<br><b>Smith, Fadeley, Keeney, Barford Funeral Home</b>  |  | 25a. DATE RECEIVED BY REGISTRY<br><b>MAR 8 1979</b>   |  |   |   |
| 106 East Church Street, Frederick, Md. 21701   |  | <b>Robert C. C. Barford</b><br><b>Robert C. C. Barford</b>  |  |   |   |

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• 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592,

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |                                       |   |   |  |   | REG. NO. 79-06990                            |  |
|--|--|---|--|---|---------------------------------------|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Lucille Marie Dotson</b> |   |                                       |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Mar 8 1979</b>   |  | 2b. HOUR<br><b>P M</b>                          |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan 5 1922</b>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b>  |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.                        |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Citizens Nursing Home</b> |  |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>   |  |   | 13b. COUNTY<br><b>Frederick</b>  |   | 13c. CITY OR TOWN<br><b>Frederick</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>311 Taney Village</b> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Luther Thompson</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Melornea S. Keays</b>  |                                       |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219 21 1931</b>  |  | 17. INFORMANT ADDRESS<br><b>Delores Ross 503 Carrollton Drive</b>   |                                       |   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral metastasis</b><br><b>1820</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma body of uterus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>2 years</b> |  |   |  |   |                                       |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Metastasis Spines</b>  |  |   |  |   |                                       |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                       |   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                       |   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 2</b> 19 <b>79</b> , to <b>March 8</b> 19 <b>79</b> , that (I) <del>was</del> last saw the deceased alive on <b>March 8</b> 19 <b>79</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above; (I) <del>will not</del> did not view the body after death.                  |  |   |  |   |                                       |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Bernard O. Thomas Jr. MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |                                       |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/9/79</b>            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bernard O. Thomas, Jr MD</b>   |  |   |  | 22e. ADDRESS<br><b>Professional Bldg Frederick, Md</b>  |                                       |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-12-1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ebenzer</b>  |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Centerville Frederick Md</b>       |   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>C.E. Nicks, 111 263 W. Patrick St, Fred.</b>  |  |   |  |   |                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 12 1979</b>                                 |   | 25b. REGISTRAR'S SIGNATURE<br><b>Dickson McCreedy</b>  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |       |  |  | REG. NO.<br>79-06991   |          |
|---|--|--|--|--|--|--|-------|--|--|--|----------|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |       |  |  |  | 2b. HOUR |
| I. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 3. SEX   |  |       |  |  | 4. RACE  |          |
| Mabel Floyd ETZLER  |  |  |  |  | Female   |  | White |  |  |  |          |
| 5. DATE OF BIRTH MONTH DAY YEAR   |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |       | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                                   |          |
| Oct. 25, 1891   |  |  |  |  | 87 YRS.  |  |       | Maryland   |  | U.S.A.   |          |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |       |  |  |  |          |
|   |  |  |  |  | Frederick County, MD.  |  |       |  |  |  |          |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |       |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |          |
| Frederick   |  |  |  |  | Frederick Nursing Center   |  |       |  |  | Homemaker  |          |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  | 13a. STATE   |  |       |  |  |  |          |
| Home  |  |  |  |  | Maryland   |  |       |  |  |  |          |
| 13b. COUNTY   |  |  |  |  | 13c. CITY OR TOWN  |  |       | 13d. INSIDE CITY LIMITS?   |  |  |          |
| Frederick   |  |  |  |  | Frederick  |  |       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |          |
| 13e. STREET ADDRESS   |  |  |  |  | 14. FATHER'S NAME FIRST MIDDLE LAST  |  |       |  |  |  |          |
| Route 10, Frederick, Md.  |  |  |  |  | Peter J. Carpenter   |  |       |  |  |  |          |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)          |  |       |  |  |  |          |
| Harriett Virginia Hall  |  |  |  |  | no none  |  |       |  |  |  |          |
| 16b. SOCIAL SECURITY NO.  |  |  |  |  | 17. INFORMANT ADDRESS  |  |       | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF |  |  |          |
| 217-56-1502   |  |  |  |  | Mrs. B. Evelyn Bartgis, 16 Norva Avenue, Frederick, Md. 21701  |  |       | 4379   |  |  |          |
|   |  |  |  |  |  |  |       | pneumonia, STAIN   |  |  |          |
|   |  |  |  |  |  |  |       | Cerebro-vascular disease - old stroke  |  |  |          |
|   |  |  |  |  |  |  |       |  |  |  |          |
|   |  |  |  |  |  |  |       | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |          |
|   |  |  |  |  |  |  |       | peripheral vascular disease  |  |  |          |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |       | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |
|   |  |  |  |  |  |  |       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |          |
|   |  |  |  |  | P.M. 19  |  |       |  |  |  |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |       | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |          |
|   |  |  |  |  |  |  |       |  |  |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 74, to March 19 79, that (I) (we) last saw the deceased alive on 22 MAR 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  | 22b. SIGNATURE DEGREE  |  |       | 22c. DATE SIGNED   |  |  |          |
|   |  |  |  |  | George I. Smith, Jr. M.D.  |  |       | X  |  |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  | 22e. ADDRESS   |  |       |  |  |  |          |
| Dr. George I. Smith, Jr., M.D.  |  |  |  |  | 804 Toll House Ave., Frederick, Md. 21701  |  |       |  |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  |  | 23b. DATE  |  |       | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |          |
| Burial  |  |  |  |  | Mar 26, 1979   |  |       | Central Cemetery   |  |  |          |
| 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |  | 23e. DATE REC'D BY REGISTRAR   |  |       | 23f. REGISTRAR'S SIGNATURE   |  |  |          |
| Libertytown, Frederick, Md.   |  |  |  |  | MAR 28 1979  |  |       |  |  |  |          |
| 24. FUNERAL DIRECTOR  |  |  |  |  | 25a. DATE REC'D BY REGISTRAR   |  |       | 25b. REGISTRAR'S SIGNATURE   |  |  |          |
| Smith, Fadelley, Keeney, Sanford Funeral Home   |  |  |  |  | MAR 28 1979  |  |       |  |  |  |          |
| 106 East Church St., Frederick, Md. 21701   |  |  |  |  |  |  |       |  |  |  |          |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR<br>STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                      |  | 79-06992  |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 3. SEX  |  | 2a. DATE OF DEATH   |  |
| ETHEL J FLATER   |  | FEMALE  |  | 3/14/79 6 <sup>00</sup> P.M.  |  |
| 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| WHITE  |  | 3 18 1901   |  | 77  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Md   |  | USA.  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| BRADDOCK HEIGHTS   |  | VINDABONA   |  | SEWOR   |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |
| Md   |  | Carroll   |  | Finksburg   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 13d. INSIDE CITY LIMITS?  |  |
| HARRY JONES  |  | MARY NOLLENBAUGH  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |
| NO   |  | 212-01-8773   |  | Dorothy Ebaugh  |  |
| 18. CAUSE OF DEATH<br>(Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a):<br>486- PNEUMONIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b):<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c):   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 MONTH  |  | ADDRESS<br>Westminster, Md.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br>GASTRO INTESTINAL BLEEDING   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 3/9 19 79, to 3/14 19 79, that (1) (we) lost<br>saw the deceased alive on 3/9 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>W. Allgair MD   |  | 22c. DATE SIGNED<br>3/14/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | 22f. DATE REC'D. BY REGISTRAR   |  |
| WAYNE ALLGAIER   |  | BRUNSWICK, MD. 21216  |  | MAR 27 1979   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial   |  | 3-16-79   |  | MEADOW BRANCH   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Robert Kyle Smith & Co. Westminster, Md.   |  | MAR 27 1979   |  | Tiffany McBrady   |  |

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of Pittsburgh  
Pittsburgh, Pa.  
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Carnegie Library of Pittsburgh  
Pittsburgh, Pa.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-06993

|   |        |   |        |   |     |  |  |
|---|--------|---|--------|---|-----|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |        | 2a. DATE OF DEATH   |        | MONTH   | DAY | YEAR   | 2b. HOUR                                     |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |        | FIRST   | MIDDLE | LAST  |     | 3 3 79 1 40 P.M.   |  |
| Annie Josephine FOSSETT   |        |   |        |   |     |  |  |
| 3 SEX   | 4 RACE | 5. DATE OF BIRTH  |        | 6. AGE (IN YEARS LAST BIRTHDAY)   |     | IF UNDER 1 YEAR  |  |
| Female  | Negro  | MONTH DAY YEAR<br>Oct. 14, 1905   |        | 73 YRS.   |     | IF UNDER 24 HRS.   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |        | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |     | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Maryland  |        | U.S.A.  |        |   |     | Frederick Co. MD.  |  |
| 10 CITY OR TOWN OF DEATH  |        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |     | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Frederick   |        | Frederick Memorial Hospital   |        | Housewife   |     |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |        | 13a. CITY OR TOWN   |        | 13d. INSIDE CITY LIMITS?  |     | 13e. STREET ADDRESS  |  |
| 13a. STATE  |        | Frederick   |        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |     | 11 E. Main St.   |  |
| Maryland  |        | New Market  |        |   |     |  |  |
| 14 FATHER'S NAME  |        | 15. MOTHER'S MAIDEN NAME  |        | ADDRESS   |     |  |  |
| FIRST MIDDLE LAST   |        | FIRST MIDDLE LAST   |        |   |     |  |  |
| Abraham - Bennett   |        | Grace - unknown   |        |   |     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |        | 16b. SOCIAL SECURITY NO.  |        | 17 INFORMANT  |     | ADDRESS  |  |
| No  |        | 217-07-9997   |        | John W. Fossett, Item 13  |     |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Liver Failure</u><br>1561<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Adenocarcinoma of bile ducts</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>Intestinal bleeding</u> |        |   |        |   |     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?   |     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |        |   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |     |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |     |  |  |
| 22a. I certify that (I) (we) attended the deceased from <u>2/24</u> 19 <u>79</u> to <u>3/2</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |        | 22b. SIGNATURE<br><u>J. Frizzell M.D.</u>   |        | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |     | 22c. DATE SIGNED<br><u>3/3/79</u>                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>James A. Frizzell</u>   |        | 22e. ADDRESS<br><u>335 Park Ave, Frederick, Md.</u>   |        | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |     | 23b. DATE<br><u>Mar. 5, 1979</u>                               |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Resthaven</u>  |        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Frederick, Frederick, Md.</u>                            |        | 24. FUNERAL DIRECTOR<br>NAME<br><u>Olin L. Molesworth, Damascus, Md.</u>  |     | 25a. DATE REG'D. BY REGISTRAR<br><u>MAR 7 1979</u>             |  |
| 25b. REGISTRAR'S SIGNATURE  |        |   |        |   |     |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  | REG. NO. 79-06994   |  |
|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GOLDIE IRENE FREE</b>   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>17</b> YEAR <b>1979</b>                         |   |  | 2b. HOUR <b>4:05</b> P. <b>P.</b> M.   |  |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>September</b> DAY <b>3</b> YEAR <b>1917</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | 8. IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>                |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.                       |  |  |  |   |  |
| 12. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE <b>Md.</b> 16b. COUNTY <b>Wash.</b> 16c. CITY OR TOWN <b>Lagerstown</b>  |  |   |  |  | 17. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 18. STREET ADDRESS<br><b>222 W. Franklin St.</b> |  |  |   |  |
| 19. FATHER'S NAME<br>FIRST <b>JACOB</b> MIDDLE <b>R.</b> LAST <b>NAVE</b>  |  |   |  |  | 20. MOTHER'S MAIDEN NAME<br>FIRST <b>REBECCA</b> MIDDLE <b></b> LAST <b>LONG</b>               |   |  |  |  |   |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 22. SOCIAL SECURITY NO.<br><b>213-16-1935</b>   |  | 23. INFORMANT ADDRESS<br><b>21769 Mrs. Dorothy Young Middletown, Md.</b>   |  |   |  |  |  |   |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic CA lung</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1629</b> |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 months</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b></b>  |  |   |  |  |  |   |  |  |  |   |  |
| 25a. DATE OF OPERATION   |  | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 26a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 27b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |   |  |
| 28a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 28b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 28c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |   |  |
| 29a. I certify that (I) (this hospital) attended the deceased from <b>July 1977</b> to <b>1979</b> , that (I) (we) last saw the deceased alive on <b>17 Mar 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                      |  |   |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE<br><b>Officer Jmm</b>   |  |   |  | DEGREE <b></b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 29c. DATE SIGNED<br><b>3-18-79</b>                              |  |
| 29d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. T. F. Hickey</b>   |  |   |  | 29e. ADDRESS<br><b>Frederick, Md. 21701</b>  |  |   |  |  |  |   |  |
| 30a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 30b. DATE<br><b>Mar. 20, 1979</b>   |  | 30c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Memorial Gardens</b>   |  | 30d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick Md.</b>                  |  |  |  |   |  |
| 31. FUNERAL DIRECTOR<br>NAME<br><b>Gladhill Co. Middletown, Md. 21769</b>  |  |   |  | 31b. ADDRESS<br><b></b>  |  | 31c. DATE REC'D. BY REGISTRAR<br><b>MAR 21 1979</b>                                 |  | 31d. REGISTRAR'S SIGNATURE<br><b></b>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO. 79-06995   |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Margaret A. FRYER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 31, 1979</b> |   |  | 2b. HOUR<br><b>3:00 P.M.</b>   |  |  |  |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 9, 1923</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>55</b>                                   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>55</b>   |  | 7b. IF UNDER 24 HRS<br>HOURS MIN.<br><b>55</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD.</b>                 |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1309 Pinewood Drive</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurane Company</b>   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  |   |  | 13b. COUNTY<br><b>Frederick</b>  |  | 13c. CITY OR TOWN<br><b>Frederick</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>J. Marion Riley</b>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ada M. Robey</b>                 |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>none</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>232-24-2986</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>1309 Pinewood Drive<br/>Edward R. Fryer, Brederick, Md. 21701</b>  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Gastrointestinal hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of pancreas</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1579</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>10 months</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>June 5, 1978</b> to <b>March 31, 1979</b> , that (I) (we) lost<br>saw the deceased alive on <b>March 30, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |   |  |
| 23a. SIGNATURE<br><b>LeRoy T. Davis</b>  |  |   |  |   |  | DEGREE<br><b>M.D.</b>  |  | 23b. DATE SIGNED<br><b>4/2/79</b>  |  | 23c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 24. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. LeRoy T. Davis M.D.</b>   |  |   |  |   |  | 25. ADDRESS<br><b>Fountainview Medical Center, Frederick, Md.</b>                    |  |  |  |   |  |
| 26a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 26b. DATE<br><b>April 4, 1979</b>   |  | 26c. NAME OF CEMETERY OR CREMATORY<br><b>Bridgeport Cemetery</b>  |  | 26d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bridgeport, Harrison, W. Va.</b>    |  |  |  |   |  |
| 27. FUNERAL DIRECTOR<br><b>Richard C.C. Burford</b><br><b>Smith, Fadeley, Keeney, Basford Funeral Home</b><br><b>106 East Church Street, Frederick, Md. 21701</b>  |  |   |  |   |  | 28. DATE REC'D. BY REGISTRAR<br><b>APR 6 1979</b>                                    |  | 29. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  | REG. NO. 79-06996  |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>RUTH Siegel GOLDBERG  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 3 16 79  |  |   | 2b. HOUR<br>3:35 A.M.                    |  |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11-11-1886   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>FREDERICK County, MD.   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  |   | 12b KIND OF BUSINESS OR INDUSTRY<br>Home |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE Maryland 13b COUNTY Frederick 13c CITY OR TOWN Braddock Heights 13d INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  | 13e STREET ADDRESS<br>Braddock Heights, Maryland   |  |   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>William Siegel   |  |   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Henrietta Strauss   |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b SOCIAL SECURITY NO.<br>none   |  | 17 INFORMANT<br>Mrs. Irving Weil, Brooklawn Apts, Frederick,  |  | ADDRESS  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) Atherosclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br>5 yrs + |  |   |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |  |  |
| 19a DATE OF OPERATION  |  |   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from March 14, 1979 to March 16, 1979, that (I) (we) last saw the deceased alive on March 16, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Henry V. Chase MD  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>16 Mar. 79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Henry V. Chase MD   |  |   |  |   |  | 22e. ADDRESS<br>804 Toll House Ave Frederick MD  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>Mar 18, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Resthaven Mem. Gardens   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Md.                |  |  |  |
| 24. FUNERAL DIRECTOR<br>Richard C. C. Basford<br>Smith, Fadeley, Keeney, Basford Funeral Home<br>106 East Church Street, Frederick, Md. 21701  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 22 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                     |  |   |   |  |  |  |   |  | REG. NO. 79-06997                                       |  |
|---|---------------------|--|---|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN RAPHAEL GRASSIELLO</b>  |                     |  |   |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>3 11 19 530</b> |  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>24</b> YEAR <b>60</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>18</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>3</b> DAY <b>11</b> YEAR <b>19 530</b>                                    |  | 2d. HOUR <b>PM</b>  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>FREDERICK</b> MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Jefferson</b>   |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HORINE ROAD</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self-employed</b>                          |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                     |  |   |   |  |  |  |   |  |   |  |
| 13a. STATE<br><b>Md.</b>  |                     | 13b. COUNTY<br><b>Fredrick</b>   |   | 13c. CITY OR TOWN<br><b>Jefferson</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  | 13e. STREET ADDRESS<br><b>4719 Jefferson Pike</b>                                   |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>JOHN</b> MIDDLE <b>R.</b> LAST <b>GRASSIELLO</b>  |                     |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Nancy</b> MIDDLE <b>VINCENT</b> LAST <b></b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |                     | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>PARENTS</b>   |  | ADDRESS<br><b>Jefferson, Md.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Trauma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br><b>8190</b>   |                     |  |   |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                     |  |   |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |                     |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                     |  |   | 21b. TIME OF INJURY<br>HOUR <b>5</b> AM. MONTH <b>3</b> DAY <b>11</b> YEAR <b>19 79</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>1 car onto - Driveway</b>  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                     |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.)<br><b>Hiway</b>   |  | 21f. LOCATION<br>STREET <b>Horine Rd</b> CITY OR TOWN <b>Fredrick</b> COUNTY <b>Frederick</b> STATE <b>Md.</b> |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                     |  |   |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Robert J. Thomas</b>   |                     |  |   | TITLE (SPECIFY)<br><b>Deputy</b> MEDICAL EXAMINER   |  |  |  | DATE SIGNED<br><b>3-11-79</b>   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Robert J. Thomas, M.D.</b>   |                     |  |   | ADDRESS<br><b>Frederick, Md. 21701</b>  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |                     | 23b. DATE<br><b>3/14/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. ZION</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>FEAGUEVILLE</b> COUNTY <b>FREDERICK</b> STATE <b>MD.</b>                      |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Feete Funeral Home</b> ADDRESS <b>BRUNSWICK, Md.</b>  |                     |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 15 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Pitney McBrady</b>  |  |   |  |   |  |

10030-2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                   |  |   |  |   |  |   |  |   |  |
|---|--|-------------------|--|---|--|---|--|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>1- STATE REGISTRAR</p> </div> <div> <p>REG. NO. <b>79-06998</b></p> </div> </div>   |  |                   |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |                   |  |   |  | 2a. DATE KNOWN OF DEATH   |  |   |  |   |  |
| <div style="display: flex; justify-content: space-between;"> <div>FIRST<br/><b>Brawner</b></div> <div>MIDDLE<br/><b>Z.</b></div> <div>LAST<br/><b>Harding</b></div> </div>  |  |                   |  |   |  | <div style="display: flex; justify-content: space-between;"> <div>MONTH<br/><b>3</b></div> <div>DAY<br/><b>25</b></div> <div>YEAR<br/><b>1979</b></div> <div>TIME<br/><b>3:04 PM</b></div> </div> |  |   |  |   |  |
| 3. SEX  |  | 4. RACE           |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                        |  |
| <b>Male</b>   |  | <b>White</b>      |  | <b>Dec. 13 1901</b>   |  | <b>77 YRS.</b>  |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |                   |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH    |  |
| <b>Maryland</b>   |  |                   |  | <b>U.S.A.</b>   |  |   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | <b>Frederick County</b> MD.             |  |
| 10. CITY OR TOWN OF DEATH   |  |                   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  | 12b. KIND OF BUSINESS OR INDUSTRY       |  |
| <b>Frederick</b>  |  |                   |  | <b>Frederick Memorial Hospital</b>                          |  |   |  | <b>Bldg. Contractor</b>   |  | <b>Construction</b>                     |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                   |  |   |  |   |  |   |  |   |  |
| 13a. STATE  |  | 13b. COUNTY       |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |   |  |
| <b>Md.</b>  |  | <b>Montgomery</b> |  | <b>Gaithersburg</b>   |  | <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>  |  | <b>11 Montgomery Ave.</b>   |  |   |  |
| 14. FATHER'S NAME   |  |                   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |
| <div style="display: flex; justify-content: space-between;"> <div>FIRST<br/><b>Zachariah</b></div> <div>MIDDLE<br/><b></b></div> <div>LAST<br/><b>Harding</b></div> </div>  |  |                   |  |   |  | <div style="display: flex; justify-content: space-between;"> <div>FIRST<br/><b>Mary</b></div> <div>MIDDLE<br/><b>Belle</b></div> <div>LAST<br/><b>Thompson</b></div> </div>                       |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |                   |  | 16b. SOCIAL SECURITY NO.                                    |  |   |  | 17. INFORMANT ADDRESS   |  |   |  |
| <b>No</b>   |  |                   |  | <b>217-32-0895</b>  |  |   |  | <b>Marie Briggs Harding 11 Montgomery Ave. Gaithersburg, Md.</b>                      |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 Atherosclerotic Cardiovascular Disease</b>   |  |                   |  |   |  |   |  |   |  |   |  |
| <div style="display: flex; justify-content: space-between;"> <div> <p>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.</p> </div> <div> <p>(b) DUE TO, OR AS A CONSEQUENCE OF</p> </div> <div> <p>(c) DUE TO, OR AS A CONSEQUENCE OF</p> </div> </div>   |  |                   |  |   |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |                   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  | 20. AUTOPSY?  |  |   |  |
|   |  |                   |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19        |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |   |  |
|   |  |                   |  |   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
|   |  |                   |  |   |  |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                   |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Robert J. Thomas</b>  |  |                   |  |   |  | TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER  |  |   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Robert J. Thomas, M.D.</b>   |  |                   |  |   |  | ADDRESS <b>812 Toll House Ave. Frederick, Md. 21701</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |
| <b>Burial</b>   |  |                   |  | <b>March 29, 79</b>   |  | <b>Forest Oak Cemetery</b>  |  |   |  | <b>Gaithersburg Montg. Maryland</b>     |  |
| 24. FUNERAL DIRECTOR <b>Grossbill Sandison</b>  |  |                   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1979</b>  |  |   |  |   |  |
| <b>Gartner-Sandison F.H. 316 E. Diamond Ave. Gaithersburg, Md.</b>  |  |                   |  |   |  | <b>Robert J. Thomas</b>   |  |   |  |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |  |  |   |  | REG. NO. 79-06999   |  |  |  |
|--|--|------------------|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Mark W. Ihmle   |  |                  |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED MONTH DAY YEAR<br>3 4 19 79                    |  | 2b. HOUR<br>M                                |  |
| 3. SEX<br>male   |  | 4. RACE<br>white |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 20 1956  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>22 YRS. |  | 7. IF UNDER 24 YRS.<br>MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 7 19 79                             |  | 2d. HOUR<br>M                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SOUTH CAROLINA  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County MD.                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>NONE  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sugar Loaf Mountain |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>STOCKMAN-WOODWARD & LOTHROP  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br>MARYLAND   |  |                  |  | 13b. COUNTY<br>MONTGOMERY   |  | 13c. CITY OR TOWN<br>GAITHERSBURG                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>19222 RACINE CT.   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GORDON F. IHMLE  |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EVELYN LEE            |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>218-78-1595   |  |  |  | 17. INFORMANT<br>ADDRESS<br>GORDON F. IHMLE (SAME AS 13e)   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Blunt injury to head with brain contusions<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                  |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 3-4- 19 79  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject fell.  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>mountain   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Sugar Loaf Mountain Frederick Md.  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |  |  |   |  | DATE SIGNED<br>3-8-79   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |  |                  |  | ADDRESS<br>111 Penn St.   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |                  |  | 23b. DATE<br>3-13-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LIVE OAK MEMORIAL GARDENS        |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CHARLESTON SOUTH CAR.                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES P/A   |  |                  |  | ADDRESS<br>ROCKVILLE MD.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1979  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>R. H. H. H.    |  |

00000-05

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED]

RE: [REDACTED]

DATE: [REDACTED]

BY: [REDACTED]

FOR: [REDACTED]

BY: [REDACTED]

FOR: [REDACTED]

BY: [REDACTED]

FOR: [REDACTED]

BY: [REDACTED]

FOR: [REDACTED]

BY: [REDACTED]

FOR: [REDACTED]

BY: [REDACTED]

FOR: [REDACTED]

BY: [REDACTED]

FOR: [REDACTED]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 79-07000   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary Elizabeth Jacobs   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 25 1979   |  | 2b. HOUR<br>10:40a <sub>M</sub>   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 13 1905   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>73 4 12   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Citizens Nursing Home |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Frederick  |  | 13c. CITY OR TOWN<br>Mt. Airy   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Marshall Smith   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Bessie Warner   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>2-14-28-5693A   |  | 17. INFORMANT ADDRESS<br>Bessie E. DeGrange, Ft. Myers, Fla. Route 11   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renal failure with coma</u><br>1809<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Metastatic carcinoma of cervix with unilateral obstruction</u><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Anemia</u>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>William G. Miller, MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>3/25/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William G. Miller, MD  |  |   |  | 22e. ADDRESS<br>K8 Thompson Johnson Dr. Frederick, MD   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3-28-1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Locust Grove  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Frederick, Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Charles W. Burrier, Jr., Sykesville, Md.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 28 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McBrady   |  |

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-07001

REG. NO.

|   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ESTELLA SUSAN KLINE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-2-79</b>                   |  |  | 2b. HOUR<br><b>8:15</b> PM   |  |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Cau.</b>   |  | 5 DATE OF BIRTH<br>DAY MONTH YEAR<br><b>March 2, 1979</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79-79</b>                                       |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.                          |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Frederick</b>  |  | 13c. CITY OR TOWN<br><b>Myersville</b>   |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elmer Poffinberger</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida Harshman</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-20-4063</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Stanley Kline Myersville, Md.</b>  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS</b><br><b>4402</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>GANGRENE LEFT FOOT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOCLEROTIC &amp; VASCULAR DISEASE</b>                               |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>ONE DAY</b><br><b>3 DAYS</b><br><b>YEARS</b> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>CEREBROVASCULAR ACCIDENT, MYOCARDIAL INFARCTION</b>  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>NA</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NA</b>          |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 19, 1979</b> , to <b>MARCH 2, 1979</b> , that (I) (we) last saw the deceased alive on <b>MARCH 2, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>James L. Roessler MD</b>   |  |   | DEGREE<br><b>MD</b>  |  |  | 22c. DATE SIGNED<br><b>3/2/79</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES L. ROESSLER MD</b>  |  |   | 22e. ADDRESS<br><b>MIDDLETOWN, MD. 21769</b>                           |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>Burial</b>   |  |   | 23b. DATE<br><b>3/5/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grossnickle Cemetery</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Myersville Frederick Md.</b>                      |   |  |
| 24. FUNERAL DIRECTOR<br><b>Bitterman Funeral Home</b>   |  |   | ADDRESS<br><b>Myersville, Md.</b>                                      |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 7 1979</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barbara McCreedy</b>  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                           |   |   |  |  |   |   | REG. NO. 79-07002   |  |
|--|--|---|---------------------------|---|---|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |                           |   | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR                           |  |  |   |   |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Barbara Smith KOONTZ  |  |   |                           |   | March 13, 1979 11:50 P.M.   |  |  |   |   |   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |                           | 5 DATE OF BIRTH MONTH DAY YEAR<br>Dec. 5, 1896  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS   |  | 7 IF UNDER 1 YEAR MONTHS DAYS   |   | 8 IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                           | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.                     |  |   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |                           |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerical worker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>welfare                                      |   |   |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Frederick  |   | 13c. CITY OR TOWN<br>Frederick                                      |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>613 Charles Street |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>William Henry Smith  |  |   |                           |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Minnie Serepta Staley |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>214-10-1256   |                           | 17. INFORMANT ADDRESS<br>Mrs. Imogene Warner, Frederick, Md. 21701  |   | 613 Charles Street   |  |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary edema.</u><br>4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Artery Disease.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischaemic</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days<br>15 years |  |   |                           |   |   |  |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Ischaemic</u>  |  |   |                           |   |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   |                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |                           | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |                           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>58</u> , to <u>March 13</u> , 19 <u>79</u> , that (I) <del>was</del> last saw the deceased alive on <u>March 13</u> , 19 <u>79</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did not</del> view the body after death.  |  |   |                           |   |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br><u>Bernard O. Thomas Jr</u>  |  |   |                           | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  | 22c. DATE SIGNED<br>3/15/79   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Bernard O. Thomas, Jr., M.D.  |  |   |                           | 22e. ADDRESS<br>Professional Building, Frederick, Md. 21701   |   |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>Mar 17, 1979 |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Olivet Cemetery         |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Md.              |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Smith, Fadelley, Keeney, Bassford Funeral Home  |  |   |                           | ADDRESS<br>106 East Church Street, Frederick, Md. 21701   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 19 1979                                      |   | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McCreedy</u>   |  |

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Mr. Gerald Thomas, Jr., 1001 ...  
 International Building, New York, N.Y.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-07003

1- FOR  
STATE  
REGISTRAR

|  |         |  |  |   |  |                                      |  |   |  |  |  |   |  |      |  |   |  |
|--|---------|--|--|---|--|--------------------------------------|--|---|--|--|--|---|--|------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST                                 |  | 2a. DATE KNOWN<br>OF ESTI-<br>MATED   |  | <input checked="" type="checkbox"/> MONTH  |  | DAY   |  | YEAR |  | 2b. HOUR  |  |
| Kenneth Peter Kupnicki   |         |  |  |   |  |                                      |  | 3   |  | 22   |  | 19  |  | 79   |  | M   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  | IF UNDER 24 HRS.                     |  | 2c. DATE<br>PRONOUNCED<br>DEAD  |  | MONTH                                      |  | DAY   |  | YEAR |  | 2d. HOUR  |  |
| Male   | White   | Jan. 1, 1951   |  | 28  |  | YRS.                                 |  | 3   |  | 22   |  | 19  |  | 79   |  | 2:00<br>A M                                     |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |  |  |   |  |      |  |   |  |
| Maryland   |         | U.S.A.   |  |   |  | Frederick County, MD.                |  |   |  |  |  |   |  |      |  |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |      |  |   |  |
|  |         | Route 97   |  |   |  |                                      |  | Sound Man   |  |  |  | Entertainment   |  |      |  |   |  |
| 13a. STATE   |         |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS                        |  |   |  |      |  |   |  |
| Maryland   |         |  |  | Fredrick  |  | Emmitsburg                           |  |   |  | Route #97                                  |  |   |  |      |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |                                      |  |   |  |  |  |   |  |      |  |   |  |
| Leo Jospeh Kupnicki, Sr.   |         |  |  | Dorothy H. Wittmer  |  |                                      |  |   |  |  |  |   |  |      |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT                        |  | ADDRESS   |  |  |  |   |  |      |  |   |  |
| No   |         |  |  | -----   |  | 212-52-6987                          |  | Leo J. Kupnicki, Sr. 8340 Ridgely Oak   |  |  |  |   |  |      |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Injuries</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |  |  |   |  |                                      |  |   |  |  |  |   |  |      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |                                      |  |   |  |  |  |   |  |      |  |   |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                                      |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |      |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |  |   |  |      |  |   |  |
|  |         |  |  | 2:00 PM 3 22 19 79  |  |                                      |  | Driver of auto/fixed object impact  |  |  |  |   |  |      |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |      |  |   |  |
|  |         |  |  | street  |  |                                      |  | Route 97  |  |  |  | Frederick, Md.  |  |      |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |                                      |  |   |  |  |  |   |  |      |  |   |  |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u>  |         |  |  | TITLE (SPECIFY)<br>Assistant  |  |                                      |  | DATE SIGNED 3/22/79   |  |  |  |   |  |      |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         |  |  | ADDRESS   |  |                                      |  |   |  |  |  |   |  |      |  |   |  |
| Virginia L. Dolan, M.D.  |         |  |  | 111 Penn Street   |  |                                      |  |   |  |  |  |   |  |      |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(S-E-C-E-V)   |         |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |   |  |      |  |   |  |
| Burial   |         |  |  | Mar. 26, '79  |  | Dulaney Valley Mem. Gar.             |  |   |  | Baltimore Co., Md.                         |  |   |  |      |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |         |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |                                      |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |      |  |   |  |
| William E. Johnson 8521 Loch Raven Blvd.   |         |  |  | MAR 27 1979   |  |                                      |  | <u>John H. Brady</u>  |  |  |  |   |  |      |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

19-01003



1951.1.19

Original: Fredrick Lindstrom

Location: Unknown, St. Dorothy

1951-52-53, No. 5, 10, 15, 20, 25, 30, 35, 40, 45, 50, 55, 60, 65, 70, 75, 80, 85, 90, 95, 100

1951-52, 1952-53, 1953-54

William, Johnson 8221 Rock River Road



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 79-07004  |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Vincent Lagrotteria  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3-26-79 6 <sup>10</sup> PM 6 <sup>10</sup> PM   |  | 2b. HOUR  |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 21 1934   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>45 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Bronx N.Y.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hosp. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Data Processing                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Civil Ser.   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Frederick   |  | 13c. CITY OR TOWN<br>Walkersville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>114 Glade Blvd.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Antonio Lagrotteria  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Maria Carmela Russo   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>Peacetime 130-26-5567  |  | 17. INFORMANT<br>Jeannine E. Lagrotteria  |  | 17. ADDRESS<br>114 Glade Blvd.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) cerebral ischemia<br>515-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) bilateral bundle branch block<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) advanced pulmonary fibrosis |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>renal failure, congestive heart failure  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Pulmonary fibrosis   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>W. C. Z. Miller, MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>3/26/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W. C. Z. Miller, MD  |  |  |  | 22e. ADDRESS<br>148 Thomas Johnson Dr. Frederick Md.  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Mar. 30, 79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glade Com.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Walkersville Fred. Md.                               |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>G. Douglas Stauffer  |  |  |  | 24. ADDRESS<br>Rt. 10 Box 66 Fred. Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 4 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McCreedy  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| Items #18a-22a Film G530 4/12/79 STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  | REG. NO. 79-07005                                      |  |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE   |  | LAST   |  | 2a. DATE KNOWN OF DEATH   |  | MONTH DAY YEAR   |  |
| BETTY FAYE LANNON  |  |   |  |  |  |  |  | 3 11 19 79  |  | 7b. HOUR   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                                       |  |
| female   |  | white   |  | Mar 27, 1933   |  | 45 YRS.  |  |   |  | 2c. DATE PRONOUNCED DEAD                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | MONTH DAY YEAR  |  | 2d. HOUR   |  |
| Maryland   |  | U.S.A.  |  |  |  | Frederick Co.  |  | 3 11 19 79  |  | 2:35 AM  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| Frederick  |  | Frederick Memorial Hospital   |  | Housewife  |  | Own Home   |  |   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland   |  | Frederick   |  | Thurmont   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | Apt 3, 23 Howard Street   |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  |  |  |
| Joseph W. JONES  |  | Alice C. MARSHALL   |  | No   |  | 217-30-1747  |  | Mark R. Lannon (Son), 201 Grand Ave., Cumberland, Maryland 21502    |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <u>Acute amitriptyline intoxication</u><br>IMMEDIATE CAUSE (a) <u>9503</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</u><br>(c) <u></u>   |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY?  |  |  |  |
|  |  |   |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)          |  | 21f. LOCATION  |  |
|  |  | 3/11/1979   |  | self-ingested  |  |  |  | Home  |  | Bldg. 1<br>23 Howard St. Apt. 6 Thurmont Fred. Co. Md. |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)   |  |  |  |  |  | DATE SIGNED   |  |  |  |
| <u>Margarita A. Korell</u>   |  | M.D. Assistant MEDICAL EXAMINER   |  |  |  |  |  | 3-12-79   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS   |  |  |  |  |  |   |  |  |  |
| Margarita A. Korell, M.D.  |  | 111 Penn St.  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | COUNTY  |  | STATE  |  |
| Burial   |  | 3/13/79   |  | Belvedere Cemetery   |  | Midland, Allegheny, Md.  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Charles Wm. Miller Funeral Home, 104 East Main Street, Thurmont, Maryland  |  | MAR 16 1979   |  |  |  |  |  | <u>Patricia A. Kelly</u>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 79-07006   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Benjamin Perry Lawson</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 8 1979</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 11 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69 67</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rt. 1, Mt. Airy</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Route 1, Mt. Airy, Maryland</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto. Mechanic</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN <b>Rt. 1.</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS<br><b>Route 1, Mt. Airy, Md.</b>           |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gabriel Uriah Lawson</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Stella M. Holland</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214 10 3885</b>   |  | 17. INFORMANT ADDRESS<br><b>H. Gladys Lawson, Rt. 1, Mt. Airy, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Larynx</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>with local recurrences</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 years</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 1 1950</b> to <b>March 8 1979</b> , that (I) <del>was</del> lost<br>saw the deceased alive on <b>March 1 1979</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>was</del> did not view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Bernard O. Thomas, Jr. M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  | 22c. DATE SIGNED<br><b>3/9/79</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bernard O. Thomas, Jr. M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>228 N. Market Street, Frederick, Maryland</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>March 12, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick Frederick Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Smith, Fadelley, Keeney &amp; Bassford Funeral Home</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1979</b> 25b. REGISTRAR'S SIGNATURE<br><b>Petry, McCready</b>   |  |  |  |
| 106 East Church Street, Frederick, Maryland  |  |  |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 79-07007  |   |
|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ANNA Isabel LEWIS   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>MARCH 31 1979  |  | 2b. HOUR<br>1:10 PM                                     |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov 28 1893  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mt. Airy, N.C.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick Co. MD.  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Frederick  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Windolaba Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY Frederick 13c. CITY OR TOWN Braddock Hgts.  |  |   | 14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 15. STREET ADDRESS<br>6004 Charlotte Dr. |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ERNEST BERNARD HORN  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY VICTORIA DEETER   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>579-38-3166B  | 17. INFORMANT ADDRESS<br>Nolan D. C. Lewis Jr. Valhalla, N. Y.   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>4029<br>DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>abd aneurysm (? RUPTURE) |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |
| 19a. DATE OF OPERATION<br>9   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1970 to March 1979, that (I) (we) lost saw the deceased alive on 26 March 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |
| 22b. SIGNATURE<br>George I. Smith Jr.   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br>31 MAR 79  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. George I. Smith Jr.  |  | 22e. ADDRESS<br>Frederick, Md.  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Apr. 3, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rest Haven Cem.  |   |
| 23d. LOCATION CITY OR TOWN<br>Frederick   |  | COUNTY<br>Fred.   |  | STATE<br>Md.   |   |
| 24. FUNERAL DIRECTOR NAME<br>Gladhill Co. Middletown, Md.   |  | ADDRESS<br>21769  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 5 1979 25b. REGISTRAR'S SIGNATURE<br>L. J. McBrady  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | REG. NO. 79-07008 |  |  |  |  |  |   |  |   |  |                                |  |                         |  |  |  |                          |  |  |  |
|---|--|--|--|--|--|---|--|--|--|-------------------|--|--|--|--|--|---|--|---|--|--------------------------------|--|-------------------------|--|--|--|--------------------------|--|--|--|
| 1. FOR REGISTERAR   |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 3-5-79   |  |  |  |                   |  | 2b. HOUR 640 P. M.   |  |  |  |   |  |   |  |                                |  |                         |  |  |  |                          |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Susan Lippincott  |  |  |  |  |  | 3. SEX F  |  |  |  |                   |  | 4. RACE W  |  | 5. DATE OF BIRTH MONTH DAY YEAR October 29, 1898 |  | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS. HOURS MIN. |  |                         |  |  |  |                          |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  |  |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.  |  |                                |  |                         |  |  |  |                          |  |  |  |
| 10. CITY OR TOWN OF DEATH Frederick   |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Nursing Center |  |  |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIFE) School Teacher   |  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                |  |                         |  |  |  |                          |  |  |  |
| 13a. STATE Md.  |  |  |  |  |  | 13b. CITY OR TOWN Frederick Walkersville  |  |  |  |                   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  | 13d. STREET ADDRESS 8375 Inspiration Ave.   |  |                                |  |                         |  |  |  |                          |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST John B. Arnold  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Koehler  |  |  |  |                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO   |  |  |  |   |  | 16b. SOCIAL SECURITY NO. 218-01-8711-D  |  |                                |  |                         |  | 17. INFORMANT ADDRESS Harry L. Lippincott, Walkersville, Md. |  |                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |  |                   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                |  |                         |  |  |  |                          |  |  |  |
| IMMEDIATE CAUSE (a) Respiratory failure   |  |  |  |  |  |   |  |  |  |                   |  |  |  |  |  |   |  | 2 days  |  |                                |  |                         |  |  |  |                          |  |  |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Lung (probable)  |  |  |  |  |  |   |  |  |  |                   |  |  |  |  |  |   |  | 10 mos.   |  |                                |  |                         |  |  |  |                          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |  |  |                   |  |  |  |  |  |   |  |   |  |                                |  |                         |  |  |  |                          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |                   |  |  |  |  |  |   |  |   |  |                                |  |                         |  |  |  |                          |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                |  |                         |  |  |  |                          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |  |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |   |  |                                |  |                         |  |  |  |                          |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |                                |  |                         |  |  |  |                          |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 3/4/79 to 3/5/79, and that in my (we) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |  |  |  |  |  |   |  |  |  |                   |  |  |  |  |  |   |  | 19 78 to 3/5/79 19 79   |  |                                |  |                         |  |  |  |                          |  |  |  |
| 22b. SIGNATURE (Type or Print) Robert J. Raymond, MD  |  |  |  |  |  |   |  |  |  |                   |  |  |  |  |  |   |  | DEGREE ATTENDING PHYSICIAN  |  |                                |  | 22c. DATE SIGNED 3/6/79 |  |  |  |                          |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |   |  |  |  |                   |  |  |  |  |  |   |  | 22e. ADDRESS  |  |                                |  |                         |  |  |  |                          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |  |  |  |  | 23b. DATE Mar. 8, 1979  |  |  |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY Beech Grove Cem.  |  |  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Pomeroy Meigs Ohio  |  |                                |  |                         |  |  |  |                          |  |  |  |
| 24. FUNERAL DIRECTOR NAME G. Douglas Stauffer, Rt. 10, Frederick, Md. 21701   |  |  |  |  |  |   |  |  |  |                   |  |  |  |  |  |   |  | 25a. MAR. 12 1979   |  |                                |  | 25b. BY REGISTERAR      |  |  |  | 25c. BY MEDICAL EXAMINER |  |  |  |

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$\frac{1}{50}$  50.  $\frac{1}{51}$  51.  $\frac{1}{52}$  52.  $\frac{1}{53}$  53.  $\frac{1}{54}$  54.  $\frac{1}{55}$  55.  $\frac{1}{56}$  56.  $\frac{1}{57}$  57.  $\frac{1}{58}$  58.  $\frac{1}{59}$  59.  $\frac{1}{60}$  60.  $\frac{1}{61}$  61.  $\frac{1}{62}$  62.  $\frac{1}{63}$  63.  $\frac{1}{64}$  64.  $\frac{1}{65}$  65.  $\frac{1}{66}$  66.  $\frac{1}{67}$  67.  $\frac{1}{68}$  68.  $\frac{1}{69}$  69.  $\frac{1}{70}$  70.  $\frac{1}{71}$  71.  $\frac{1}{72}$  72.  $\frac{1}{73}$  73.  $\frac{1}{74}$  74.  $\frac{1}{75}$  75.  $\frac{1}{76}$  76.  $\frac{1}{77}$  77.  $\frac{1}{78}$  78.  $\frac{1}{79}$  79.  $\frac{1}{80}$  80.  $\frac{1}{81}$  81.  $\frac{1}{82}$  82.  $\frac{1}{83}$  83.  $\frac{1}{84}$  84.  $\frac{1}{85}$  85.  $\frac{1}{86}$  86.  $\frac{1}{87}$  87.  $\frac{1}{88}$  88.  $\frac{1}{89}$  89.  $\frac{1}{90}$  90.  $\frac{1}{91}$  91.  $\frac{1}{92}$  92.  $\frac{1}{93}$  93.  $\frac{1}{94}$  94.  $\frac{1}{95}$  95.  $\frac{1}{96}$  96.  $\frac{1}{97}$  97.  $\frac{1}{98}$  98.  $\frac{1}{99}$  99.  $\frac{1}{100}$  100.  $\frac{1}{101}$  101.  $\frac{1}{102}$  102.  $\frac{1}{103}$  103.  $\frac{1}{104}$  104.  $\frac{1}{105}$  105.  $\frac{1}{106}$  106.  $\frac{1}{107}$  107.  $\frac{1}{108}$  108.  $\frac{1}{109}$  109.  $\frac{1}{110}$  110.  $\frac{1}{111}$  111.  $\frac{1}{112}$  112.  $\frac{1}{113}$  113.  $\frac{1}{114}$  114.  $\frac{1}{115}$  115.  $\frac{1}{116}$  116.  $\frac{1}{117}$  117.  $\frac{1}{118}$  118.  $\frac{1}{119}$  119.  $\frac{1}{120}$  120.  $\frac{1}{121}$  121.  $\frac{1}{122}$  122.  $\frac{1}{123}$  123.  $\frac{1}{124}$  124.  $\frac{1}{125}$  125.  $\frac{1}{126}$  126.  $\frac{1}{127}$  127.  $\frac{1}{128}$  128.  $\frac{1}{129}$  129.  $\frac{1}{130}$  130.  $\frac{1}{131}$  131.  $\frac{1}{132}$  132.  $\frac{1}{133}$  133.  $\frac{1}{134}$  134.  $\frac{1}{135}$  135.  $\frac{1}{136}$  136.  $\frac{1}{137}$  137.  $\frac{1}{138}$  138.  $\frac{1}{139}$  139.  $\frac{1}{140}$  140.  $\frac{1}{141}$  141.  $\frac{1}{142}$  142.  $\frac{1}{143}$  143.  $\frac{1}{144}$  144.  $\frac{1}{145}$  145.  $\frac{1}{146}$  146.  $\frac{1}{147}$  147.  $\frac{1}{148}$  148.  $\frac{1}{149}$  149.  $\frac{1}{150}$  150.  $\frac{1}{151}$  151.  $\frac{1}{152}$  152.  $\frac{1}{153}$  153.  $\frac{1}{154}$  154.  $\frac{1}{155}$  155.  $\frac{1}{156}$  156.  $\frac{1}{157}$  157.  $\frac{1}{158}$  158.  $\frac{1}{159}$  159.  $\frac{1}{160}$  160.  $\frac{1}{161}$  161.  $\frac{1}{162}$  162.  $\frac{1}{163}$  163.  $\frac{1}{164}$  164.  $\frac{1}{165}$  165.  $\frac{1}{166}$  166.  $\frac{1}{167}$  167.  $\frac{1}{168}$  168.  $\frac{1}{169}$  169.  $\frac{1}{170}$  170.  $\frac{1}{171}$  171.  $\frac{1}{172}$  172.  $\frac{1}{173}$  173.  $\frac{1}{174}$  174.  $\frac{1}{175}$  175.  $\frac{1}{176}$  176.  $\frac{1}{177}$  177.  $\frac{1}{178}$  178.  $\frac{1}{179}$  179.  $\frac{1}{180}$  180.  $\frac{1}{181}$  181.  $\frac{1}{182}$  182.  $\frac{1}{183}$  183.  $\frac{1}{184}$  184.  $\frac{1}{185}$  185.  $\frac{1}{186}$  186.  $\frac{1}{187}$  187.  $\frac{1}{188}$  188.  $\frac{1}{189}$  189.  $\frac{1}{190}$  190.  $\frac{1}{191}$  191.  $\frac{1}{192}$  192.  $\frac{1}{193}$  193.  $\frac{1}{194}$  194.  $\frac{1}{195}$  195.  $\frac{1}{196}$  196.  $\frac{1}{197}$  197.  $\frac{1}{198}$  198.  $\frac{1}{199}$  199.  $\frac{1}{200}$  200.  $\frac{1}{201}$  201.  $\frac{1}{202}$  202.  $\frac{1}{203}$  203.  $\frac{1}{204}$  204.  $\frac{1}{205}$  205.  $\frac{1}{206}$  206.  $\frac{1}{207}$  207.  $\frac{1}{208}$  208.  $\frac{1}{209}$  209.  $\frac{1}{210}$  210.  $\frac{1}{211}$  211.  $\frac{1}{212}$  212.  $\frac{1}{213}$  213.  $\frac{1}{214}$  214.  $\frac{1}{215}$  215.  $\frac{1}{216}$  216.  $\frac{1}{217}$  217.  $\frac{1}{218}$  218.  $\frac{1}{219}$  219.  $\frac{1}{220}$  220.  $\frac{1}{221}$  221.  $\frac{1}{222}$  222.  $\frac{1}{223}$  223.  $\frac{1}{224}$  224.  $\frac{1}{225}$  225.  $\frac{1}{226}$  226.  $\frac{1}{227}$  227.  $\frac{1}{228}$  228.  $\frac{1}{229}$  229.  $\frac{1}{230}$  230.  $\frac{1}{231}$  231.  $\frac{1}{232}$  232.  $\frac{1}{233}$  233.  $\frac{1}{234}$  234.  $\frac{1}{235}$  235.  $\frac{1}{236}$  236.  $\frac{1}{237}$  237.  $\frac{1}{238}$  238.  $\frac{1}{239}$  239.  $\frac{1}{240}$  240

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |                         |  | REG. NO.<br>79-07009                                       |          |  |
|--|--|--|--|---|--|--|--|-------------------------|--|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR                                 |  |  |                         |  |  | 2b. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Geraldine A. Maguire   |  |  |  |   | March 7 1979   |  |  |                         |  | 10:55 PM   |          |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>SEPT 6, 1894   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |                         |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MINNESOTA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>FREDERICK MD.                                |                         |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>FREDERICK   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FREDERICK NURSING HOME |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK ACCOUNTANT    |                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>GAO                   |          |  |
| 13a. STATE<br>MARYLAND   |  |  |  |   | 13b. COUNTY<br>MONTGOMERY  |  | 13c. CITY OR TOWN<br>SILVER SPRING   |                         | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>TIMOTHY W. ANGLIM   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>JOHANNA FITZGERALD |  |  |                         |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>217-44-0170                          |  | 17. INFORMANT ADDRESS<br>SISTER THURMONT, MD.<br>AGNES J. LOVE, 3 SANDY SPRING COURT |                         |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive heart failure<br>4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 mo.<br>5 years |  |  |  |   |  |  |  |                         |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Terminal bronchopneumonia   |  |  |  |   |  |  |  |                         |  |  |          |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                         |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |                         |  |  |          |  |
| 22a. I certify that (I) (the hospital) attended the deceased from June 1, 1978, to March 7, 1979, that (I) (we) last saw the deceased alive on March 7, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |                         |  |  |          |  |
| 22b. SIGNATURE<br>Henry V. Chase M.D.  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                         | 22c. DATE SIGNED<br>March 8, 1979  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Henry V. Chase M.D.   |  |  |  |   |  | 22e. ADDRESS<br>804 Toll House Ave Frederick MD  |  |                         |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>3/12/79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>CALVARY CEMETERY           |  |  | 23d. LOCATION<br>DUPUTH |  | COUNTY<br>MINNESOTA  |          |  |
| 24. FUNERAL DIRECTOR NAME<br>FRANCIS J. COLLINS  |  |  |  |   |  | 24a. DATE REC'D. BY REGISTRAR<br>MAR 9 1979  |  |                         | 24b. REGISTRAR'S SIGNATURE<br>Dorothy McCreedy   |  |          |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |  |  |   |  |  |  |                         |  |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2, if retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 79-07010  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Freda A. MAIN</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 10 79</b>   |  |  |  | 2b. HOUR<br><b>4:45 PM</b>   |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 12 1912</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS  |  | 7 IF UNDER 1 YEAR MONTHS DAYS  |  | 7 IF UNDER 24 HRS. HOURS MIN.                |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD.</b>                          |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>   |  |  |  |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Frederick</b>   |  | 13c CITY OR TOWN<br><b>Frederick</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>15 West 13th Street</b>  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Olin Warnick</b>   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Birdie Warnick</b>   |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b SOCIAL SECURITY NO.<br><b>218-18-5918</b>  |  | 17 INFORMANT ADDRESS<br><b>Mr. Charles V. Main, 15 West 13th Street, Frederick, Maryland 21701</b>   |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma. Breast with metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>b) <b>metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>c) <b>metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Nov 9</b> , 19 <b>77</b> , to <b>Nov 10</b> , 19 <b>79</b> , that (1) (we) lost <b>Nov 9</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Robert Thomas M.D.</b>   |  |  |  | DEGREE<br><b>MD</b>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-10-79</b>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Robert J. Thomas M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>812 Toll House Ave., Fred. Md. 21701</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Mar. 13, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Frederick Frederick Md.</b>                    |  |  |  |  |  |
| 24. SIGNATURE OF FUNERAL DIRECTOR<br><b>Edley Kennedy</b>   |  |  |  | 24b. ADDRESS<br><b>106 E. Church St., Frederick, Md. 21701</b>   |  |  |  | 25. REG. NO. OF FUNERAL HOME<br><b>14 1979</b>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |   |   |  |                                 | REG. NO. 79-07011                            |  |
|---|--|---|---|---|--|---|---|--|---------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |   | 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Maude Ellen McDonald |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 1 79 |  | 2b. HOUR<br>12 <sup>16</sup> PM |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 27 1906  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |                                 | 7. IF UNDER 24 HRS<br>HOURS MIN.             |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Montgomery, Co.  |  | 8b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD.   |   |  |                                 |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cook                           |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Restaurant  |                                 |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  | 13b. COUNTY<br>Fred.  |   | 13c. CITY OR TOWN<br>Fred.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>39 E. Fifth St.   |                                 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Wm. Smith   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Esther Shoemaker  |  |   |   |  |                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>215-26-1006-A   |   | 17. INFORMANT<br>Jesse T. McDonald  |  |   |   | 17. ADDRESS<br>707 Motter Ave.   |                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>2500<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Diabetes mellitus, insulin dependent</u><br>(c) <u>Due to, or as a consequence of</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |   |   |  |   |   |  |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |   |   |  |                                 |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |   |   |  |                                 |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/26/79</u> , 19 <u>79</u> , to <u>3/1/79</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2/26/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |   |   |  |   |   |  |                                 |  |  |
| 22b. SIGNATURE<br>Austin Beards   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |   | 22c. DATE SIGNED<br>3/1/79   |                                 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |   | 22e. ADDRESS  |  |   |   |  |                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>March 3 1979   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet  |  | 23d. LOCATION<br>CITY OR TOWN<br>Fred.  |   | 23e. COUNTY<br>Fred.   |                                 | 23f. STATE<br>Md.                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Douglas Stauffer   |  |   |   |   |  | 24b. ADDRESS<br>Rt. 10 Box 66 Fred. Md.   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 7 1979  |                                 | 25b. REGISTRAR'S SIGNATURE<br>P. J. McCreedy |  |

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78

11050-21



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  | REG. NO. 79-07012           |
|--|--|--|--|--|--|--|--|---|--|-----------------------------|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |                             |
|  |  | Charles Douglas MONGAN   |  |  |  | March 4, 1979  |  | 6:30A   |  | M                           |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 74 HRS. HOURS MIN. |
| Male   |  | White  |  | Nov. 4, 1902   |  | 76   |  |   |  |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |                             |
| Fairplay, Md.  |  | U. S. A.   |  |  |  | Frederick MD.  |  |   |  |                             |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                             |
| Middletown   |  | Rfd. 1 Box 150   |  |  |  | Labor  |  | Construction  |  |                             |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS   |  |                             |
| Maryland   |  | Frederick  |  | Middletown   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | Rfd. 1 Box 150  |  |                             |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |   |  |                             |
| Unknown  |  |  |  | Unknown  |  |  |  |   |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |                             |
| Yes  |  | Unknown  |  | 218-30-8552  |  | Mrs. Alice B. Mongan, Rfd. 1 Box 150, Middletown, Md. 21769                                  |  |   |  |                             |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ruptured abdominal aortic aneurysm</u><br>4413<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u><br><u>years</u> |  |  |  |  |  |  |  |   |  |                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |                             |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |  |  |   |  |                             |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 5</u> , 19 <u>79</u> , to <u>march</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>march 4</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |                             |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |                             |
| <u>W. R. Kang, M.D.</u>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |  | <u>3/5/79</u>   |  |                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |   |  |                             |
| <u>W. R. KANG</u>  |  |  |  | <u>1500 penn. Ave., Hagerstown, Md.</u>  |  |  |  |   |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |                             |
| Burial   |  | 3-6-79   |  | Boonsboro Cemetery   |  | Boonsboro, Wash. Co., Md.  |  |   |  |                             |
| 24 FUNERAL DIRECTOR NAME ADDRESS   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                             |
| John H. Bast, Jr. Boonsboro, Maryland 21713  |  |  |  |  |  | MAR 8 1979   |  | <u>Anthony McCready</u>   |  |                             |

19-07015



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 366-1410.

| 1. FOR STATE REGISTRAR  |   | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | REG. NO. 79-07013   |  |
|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>BABY BOY MOORE  |   | 2a. DATE OF DEATH<br>March 26, 1979  |   | 2b. HOUR<br>8:55 P.M.   |  |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>3 26 79  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>Newborn  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick   |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT AT HOME)<br>Frederick Memorial Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY                          |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY<br>Frederick   | 13c. CITY<br>Frederick  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Donna Mae Bolinger  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If YES, GIVE WAR OR DATES)<br>No   |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>MEDICAL RECORDS  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): SEVERE IMMATURITY<br>7651<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 1/2 HOUR |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |   |   |  |
| 22b. SIGNATURE<br>Walter M. Don   |   | DEGREE<br>M.D.   |   | 22c. DATE SIGNED<br>3/26/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |   | 23b. DATE<br>3-28-79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Frederick Memorial  |  |
| 23d. LOCATION (CITY OR TOWN)<br>Frederick   |   | 23e. COUNTY<br>Frederick   |   | 23f. STATE<br>Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter M. Don   |   | ADDRESS<br>Frederick Memorial Hospital   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 2 1979   |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McCreedy   |   |   |  |

19-07013

Director  
Federal Bureau of Investigation

Department of Justice

Washington, D.C.

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Dear Mr. Hoover:

RE: [illegible]

[illegible]

Very truly yours,  
[illegible signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |   |  |   |  |  | REG. NO. 79-07014   |   |  |                                 |  |
|---|--|---|---|---|---|--|---|--|--|---|---|--|---------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>CHARLES EARL NIKIRK JR. |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 25, 1979  |   |  | 2b. HOUR MIN. A.M.<br>9:08 A.M. |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 12, 1910  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS                                   |  | IF UNDER 1 YEAR MONTHS DAYS  |   | IF UNDER 24 HRS. HOURS MIN.             |  |                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick Co. MD.                   |  |  |   |   |  |                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |   |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Postmaster |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Gov't.   |   |  |                                 |  |
| 13a. STATE<br>Md.   |  |   |   |   | 13b. COUNTY<br>Fred.  |  | 13c. CITY OR TOWN<br>Middletown   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>303 W. Green St. |  |                                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Earl Nikirk Sr.  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Grace Karn                      |  |   |  |  |   |   |  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>W.W.II  |   | 17. INFORMANT ADDRESS<br>21769  |   |  | Mrs. Naomi Nikirk Middletown, Md.   |  |  |   |   |  |                                 |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>- 30 min |  |   |   |   |   |  |   |  |  |   |   |  |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |   |   |   |  |   |  |  |   |   |  |                                 |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |   |   |  |                                 |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |  |   |   |  |                                 |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Feb - 15</u> , 19 <u>76</u> , to <u>March 25</u> , 19 <u>79</u> , that (1) (we) lost saw the deceased give on <u>Feb - 15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.   |  |   |   |   |   |  |   |  |  |   |   |  |                                 |  |
| 22b. SIGNATURE<br>W J Riddick MD  |  |   |   |   | DEGREE<br>MD  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/26/79   |   |  |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Willis J. Riddick  |  |   |   |   | 22e. ADDRESS<br>Frederick, Md. 21701  |  |   |  |  |   |   |  |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>Mar. 27, 1979  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Reformed Cemetery                       |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Middletown Fred. Md.  |  |   |   |  |                                 |  |
| 24. FUNERAL DIRECTOR NAME<br>Gladhill Co. Middletown, Md.   |  |   |   |   | 24b. ADDRESS<br>21769   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 28 1979                                |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |   |   |  |                                 |  |

BP

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Items #1a-22a Film G530 4/12/79 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR  
 1- STATE REGISTRAR

REG. NO. 79-07015

|  |  |   |   |  |  |   |   |   |  |  |
|--|--|---|---|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Vanessa Marie Norwood   |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>3 21 19 79 |  |  | 2b. HOUR<br>M<br>11:00  |   |   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 24, 1961  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>17 YRS  |   | 7. IF UNDER 1 YR.<br>MONTHS DAYS<br>8 27  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None                                 |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Carroll  |  | 13c. CITY OR TOWN<br>Mt. Airy                            |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>Route 2               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John William Norwood   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Elizabeth Sager                                 |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                           |   |   | 16b. SOCIAL SECURITY NO.<br>219-58-0971      |  |
| 17. INFORMANT<br>John W. Norwood, Same As #13  |  |   | 17. ADDRESS   |  |  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9804 IMMEDIATE CAUSE (a) Gastric content inhalation<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) Fluorocarbon intoxication<br>(c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).        |  |   |   |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   | 21b. TIME OF INJURY<br>HOUR AM MONTH DAY YEAR<br>10:30 P.M. 3/21/ 1979                                |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Decedent inhaled PAM |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Home                                   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>7 Frederick St. Walkersville Md.                 |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> . |  |   |   |  |  |   |   |   |  |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan M.D.   |  |   | TITLE (SPECIFY)<br>Assistant  |  |  | MEDICAL EXAMINER  |   |   | DATE SIGNED<br>3/22/79                       |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |  |   | ADDRESS<br>111 Penn Street  |  |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>3-24-1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Resthaven Memorial |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick, Md.                        |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles W. Burrier, Jr., Sykesville, Md.   |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1979  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

21070-01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |  | REG. NO. 79-07016                            |  |
|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Dr Douglas Elwood Orndorff</u>  |  |   |  |  |  | 2a. DATE OF DEATH MONTH <u>3</u> DAY <u>3</u> YEAR <u>79</u>                      |  | 2b. HOUR <u>1130A.</u> M  |  |  |  |
| 3. SEX <u>male</u>  |  | 4. RACE <u>W</u>  |  | 5. DATE OF BIRTH MONTH <u>8</u> DAY <u>28</u> YEAR <u>15</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>63</u> YRS                                     |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>USA Maryland</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>FREDERICK</u> MD.                         |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <u>Frederick</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Frederick Memorial Hospital</u> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Plumber</u>      |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>   |  |  |  |
| 13a. STATE <u>MD</u>  |  |   | 13b. COUNTY <u>Frederick</u>   |  | 13c. CITY OR TOWN <u>same</u>                                |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <u>10 Winchester St. Frederick</u> |  |  |
| 14. FATHER'S NAME FIRST <u>Hildy</u> MIDDLE <u>S.</u> LAST <u>Orndorff</u>  |  |   | 15. MOTHER'S MAIDEN NAME FIRST <u>Sadie</u> MIDDLE <u>Michael</u> LAST <u></u> |  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>   |  |   | 16b. SOCIAL SECURITY NO. <u>XXXXXXXXXX</u>                                     |  | 17. INFORMANT ADDRESS <u>10 Winchester St Frederick, Md.</u> |   |  |   |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hemorrhagic Shock</u><br><u>1619</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma and Radiation</u> |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1619</u>  |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION <u>May 78</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Obstructing Longlegged Carcinoma</u>  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/24</u> , 19 <u>79</u> , to <u>3/3</u> , 19 <u>79</u> , that (I) <del>(we)</del> lost saw the deceased alive on <u>3/2</u> , 19 <u>79</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) view the body after death.              |  |   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE <u>Gerald M. Reed</u> DEGREE <u>D.O.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |  |  | 22c. DATE SIGNED <u>3/3/79</u>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Gerald M. Reed</u>   |  |   |  |  |  | 22e. ADDRESS <u>335 PARK AVE.</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | 23b. DATE <u>3-7-79</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Frederick, Frederick Md.</u>           |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <u>Robert E. Parley &amp; Son</u>   |  |   |  | ADDRESS <u>1210 W. Market St. Frederick, Md.</u>   |  | 25a. DATE RECEIVED BY REGISTRAR <u>MAR 8 1979</u>                                 |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |  |  |

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19-07016



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | REG. NO.<br>79-07017 |
|---|--|---|--|---|--|---|--|--|--|----------------------|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Marilyn Ruth Ottinger  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3-24-79   |  | 2b. HOUR<br>8:40 PM  |  |                      |
| 3. SEX<br>F   |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 4 46   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>33 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Milford, Del.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD  |  |  |  |                      |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>School teacher                 |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                      |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Washington   |  | 13c. CITY OR TOWN<br>Knoxville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>Rt. 2, Box 226 C-I  |  |                      |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Clarence Jarrell   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ruth Bohannon   |  |   |  |   |  |  |  |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>222-28-9221   |  | 17. INFORMANT ADDRESS<br>John W. Ottinger Rt. 2, Box 226 C-I Knoxville Md.  |  |   |  |  |  |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal cancer</u><br>1535 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent carcinoma of</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>appendix with peritoneal carcinomatosis</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): |  |   |  |   |  |   |  |  |  |                      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |                      |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                      |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |                      |
| 22b. SIGNATURE <u>EDWARD SOLANO</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |   |  |   |  | 22c. DATE SIGNED   |  |                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWARD SOLANO  |  |   |  | 22e. ADDRESS<br>4447th Street, Frederick Md.  |  |   |  |  |  |                      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Mar. 27, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Brownsville, Hgts.  |  | 23d. LOCATION<br>Brownsville  |  | 23e. COUNTY<br>Md.   |  |                      |
| 24. FUNERAL DIRECTOR NAME<br>G. Douglas Stauffer  |  |   |  | 24b. ADDRESS<br>Rt. 10 Box 66 Fred. Md.   |  | 24c. DATE REC'D. BY REGISTRAR<br>APR 4 1979   |  | 24d. REGISTRAR'S SIGNATURE<br><u>Robert McCreedy</u>   |  |                      |

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78

13-01013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |   | REG. NO. 79-07018                               |  |  |
|---|--|---|--|---|--|--|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><i>Louise Est Perry</i>   |  |   | 2a. DATE OF DEATH<br>MONTH <i>3</i> DAY <i>6</i> YEAR <i>19</i>                    |   |  | 2b. HOUR<br><i>6:35</i> M  |  |  |   |   |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH <i>Dec.</i> DAY <i>29</i> YEAR <i>1895</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>83</i> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <i></i> DAYS <i></i>  |   | 8. IF UNDER 24 HRS<br>HOURS <i></i> MIN <i></i> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Frederick County, MD.</i>   |  |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Frederick</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Frederick Memorial Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Clerk</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Retail</i>   |   |   |  |  |
| 13a. STATE<br><i>Maryland</i>   |  |   | 13b. COUNTY<br><i>Frederick</i>  |   |  | 13c. CITY OR TOWN<br><i>Frederick</i>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><i>622 Trail Ave.</i> |  |
| 14. FATHER'S NAME<br>FIRST <i>Charles</i> MIDDLE <i>F.</i> LAST <i>Cramer</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Lula</i> MIDDLE <i>E.</i> LAST <i>Lambert</i> |   |  |  |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>   |  |   | 16b. SOCIAL SECURITY NO.<br><i>217-18-8764</i>                                     |   |  | 17. DECEASED'S ADDRESS<br><i>Mrs. Lula E. Larkin, 622 Trail Ave.<br/>Frederick, Maryland 21701</i>   |  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i><br><i>4009</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Arteriosclerotic and Hypertensive Cardiovascular Disease with Atrial Fibrillation</i><br>DUE TO, OR AS A CONSEQUENCE OF<br><i>Valvular Disease with Atrial Fibrillation</i> |  |   |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Previous Stroke (1974)</i>  |  |   |  |   |  |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M.</i> <i>19</i>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1970</i> to <i>March 6</i> , 1979, that (I) (we) most saw the deceased alive on <i>March 6</i> , 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |   |   |  |  |
| 22b. SIGNATURE<br><i>Gilbert F. Meadors, Jr.</i>  |  |   | DEGREE<br><i>MD</i>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><i>March 6, 1979</i>  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>GILBERT F. MEADORS, JR MD</i>   |  |   | 22e. ADDRESS<br><i>810 TOLL House Ave FREDERICK, MD</i>                            |   |  |  |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |   | 23b. DATE<br><i>Mar 9 1979</i>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Olivet Cemetery</i>   |  |  | 23d. LOCATION<br><i>Frederick Frederick Md.</i>   |   |  |  |
| 24. FUNERAL DIRECTOR<br><i>Smith Fadelley</i>   |  |   | 24b. ADDRESS<br><i>106 E. Church St., Frederick, Md. 21701</i>                     |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>Mar 1 ~ 1979</i>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jeffrey McBrady</i>  |   |  |  |

BP

18-07018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-07019

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |   |  |  |  |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Margaret Elizabeth Plotner</i>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>3 1 79</i>                      |   |  | 2b. HOUR<br><i>3:30 PM</i>   |   |  |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11 11 29</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>49</i> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Frederick</i> MD.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Frederick</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Frederick Memorial Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><i>Maryland</i>   |  |   | 13b. COUNTY<br><i>Frederick</i>  |   | 13c. CITY OR TOWN<br><i>Frederick</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Franklin M. Shankle</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Margaret Cole</i>  |   |  | 16. ADDRESS<br><i>Maryland</i>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>   |  |   | 16b. SOCIAL SECURITY NO.<br><i>215 26 8448</i>                         |   | 17. INFORMANT<br><i>Allen L. Plotner</i>                                       |  |   |  | ADDRESS<br><i>618 Biggs Ave. Frederick</i> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cancer with extensive metastases</i><br><i>1749</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Pancytopenia</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |   |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/23/79</i> 19____, to <i>3/1/79</i> 19____, that (I) (we) lost saw the deceased alive on <i>2/28/79</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.   |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Austin Pearre</i>  |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>3/1/79</i>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Austin Pearre, Jr. M.D.</i>   |  |   | 22e. ADDRESS<br><i>Toll House Avenue, Frederick, Maryland</i>          |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>March 3, 1979</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Resthaven Mem. Gardens</i>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Frederick Frederick Md.</i>                    |  |  |  |
| 24. FUNERAL HOME<br>NAME ADDRESS<br><i>Smith, Fideley, Keeney &amp; Bassford Funeral Home</i><br><i>106 East Church Street, Frederick, Maryland</i>   |  |   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><i>MAR 5 1979</i>  |   |  |  |  |
| REGISTRAR'S SIGNATURE<br><i>Anthony McCready</i>  |  |   |  |   |  |  |   |  |  |  |



19-07019

x

x

Reston, Va. D. C. Toll Free

Reston, Va. D. C. Toll Free

Reston, Va. D. C. Toll Free

Reston, Va. D. C. Toll Free

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |   |  | REG. NO. 79-07020 |  |
|--|--|---|--|--|--|---|--|--|--|---|--|-------------------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |   |  |  |  |   |  |                   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Reginald LeRoy Poffinberger</i>  |  |   |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><i>3 2 79</i>  |  | 2b HOUR<br><i>5<sup>15</sup> PM</i>  |  |   |  |                   |  |
| 3 SEX<br><i>male</i>   |  | 4 RACE<br><i>White</i>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><i>April 5, 1907</i>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>71</i> YRS   |  | 7 IF UNDER 1 YEAR MONTHS DAYS  |  | 8 IF UNDER 74 HRS HOURS MIN.  |  |                   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md.</i>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Frederick Co.</i> MD.                             |  |  |  |   |  |                   |  |
| 10 CITY OR TOWN OF DEATH<br><i>Frederick</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Frederick Memorial Hosp.</i> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Laborer</i>              |  | 12b KIND OF BUSINESS OR INDUSTRY<br><i>County Roads</i>                          |  |   |  |                   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE 13c COUNTY 13d CITY OR TOWN<br><i>Md. Frederick Middletown</i>   |  |   |  |  |  | 13e INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13f STREET ADDRESS<br><i>3511 Roy Shafer Rd.</i>                                 |  |   |  |                   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><i>ARTHUR REGINALD POFFINBERGER</i>  |  |   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>ALVIRA ELIZABETH TRITAPOE</i>               |  |  |  |   |  |                   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |  |   |  | 16b SOCIAL SECURITY NO.<br><i>212-24-6442</i>  |  | 17 INFORMANT ADDRESS<br><i>Mrs. Ruth Poffinberger Middletown, Md.</i>                       |  |  |  |   |  |                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br><i>4280</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Comp Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Azotemia - Uremia</i> |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 days</i><br><i>6 weeks</i><br><i>4 weeks</i>                       |  |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |  |  |   |  |                   |  |
| 19a DATE OF OPERATION  |  |   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |  |  |  |   |  |                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                   |  |
| 22a I certify that (1) this hospital attended the deceased from <i>1/14/79</i> to <i>3/2/79</i> , that (2) (we) last saw the deceased alive on <i>3/1/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated                               |  |   |  |  |  |   |  |  |  |   |  |                   |  |
| 22b SIGNATURE<br><i>Robert L. Kaufmann</i> DEGREE MD   |  |   |  |  |  |   |  |  |  | 22c. DATE SIGNED<br><i>3/2/79</i>   |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Robert L. Kaufmann</i>   |  |   |  |  |  | 22e ADDRESS<br><i>Frederick, Md. 21701</i>  |  |  |  |   |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  |   |  | 23b. DATE<br><i>Mar. 5, 1979</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lutheran Cem.</i>                                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Middletown Fred. Md.</i>           |  |   |  |                   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><i>Gladhill Co. Middletown, Md. 21769</i>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 7 1979</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Barney McCreedy</i>                             |  |   |  |                   |  |

County

State of New York

City of New York

County of New York

City of New York

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 79-07021  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Warden Otmer Rose  |  |  |  |   |  | 3/7/79   |  | 4:10 PM   |  |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 23, 1904  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick Co. MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Forester   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Montgomery Clarksburg  |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>14308 Lewisdale Rd.                                |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lewis O Rose   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dona - Helms  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>233-26-9079   |  | 17. INFORMANT<br>ADDRESS<br>Belva M. Rose, Item 13  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoid, pulmonary</u><br>1629 DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____       |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 17</u> , 19 <u>22</u> , to <u>Sept 7</u> , 19 <u>29</u> , that (I) (we) last saw the deceased alive on <u>Aug 7</u> , 19 <u>29</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>D. Stone</u>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>5-7-79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thomas STONE  |  |  |  |   |  | 22e. ADDRESS<br>Frederick MD   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>Mar. 10, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Forest Oak   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Gaithersburg Montgomery Md. |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Olin L. Molesworth, Damascus, Md.  |  |  |  |   |  | 25a. DATE AND BY REGISTER<br>3/12/79   |  | 25b. REGISTER SIGNATURE<br><u>[Signature]</u>                             |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |  | REG. NO. 79-07022  |  |
|---|--|--|--|--|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |  | 2b. HOUR - MIN.  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Benjamin Braffman Rosenstock   |  |  |  |  | 3 SEX Male  |  |  |  |  | 4 RACE White   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 7 1902  |  |  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>77                         |  |  |  |  | 7b. HOUR - MIN. 8 05 P.M.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.  |  |  |  |  | 10 CITY OR TOWN OF DEATH<br>Frederick   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Mem. Hospital  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Lawyer   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>- - - - -                                |  |  |  |  | 13a. STREET ADDRESS<br>Rt. #10, Frederick, Md.   |  |
| 13a. STATE Maryland   |  |  |  |  | 13b. COUNTY Frederick   |  |  |  |  | 13c. CITY OR TOWN Frederick  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Jacob Rosenstock  |  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Nettie Braffman                  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no   |  |
| 16b. SOCIAL SECURITY NO. 212-38-8548  |  |  |  |  | 17. INFORMANT ADDRESS<br>Mrs. Edna C. Rosenstock, same as above in item #13c. |  |  |  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Bacterial Sepsis<br>2041<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) Chronic Lymphocytic Leukemia<br>(c) Cryptococcal meningitis<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASHD |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                          |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/6/68, 19, to 3/16/79, 19, that (I) (we) lost the deceased alive on 3/16/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we did) (did not) view the body after death. |  |  |  |  | 22b. SIGNATURE Austin Pearre  |  |  |  |  | 22c. DATE SIGNED 3/17/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Austin Pearre, Jr. M.D.   |  |  |  |  | 22e. ADDRESS 804 Toll House Ave., Fred. Md. 21701                             |  |  |  |  | 22f. MEDICAL ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation   |  |  |  |  | 23b. DATE Mar. 19, 1979   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory   |  |
| 23d. LOCATION Smith-Padeley Keeney-Bastford Funeral Home  |  |  |  |  | 23e. ADDRESS 106 E. Church St., Frederick, Md. 21701                          |  |  |  |  | 23f. LOCATION Brentwood Prince George Md.  |  |

Jan. 7 1905

Frederick County,

Frederick Mem. Hospital

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-07023

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |   |  |                                       |  |
|---|--|---|--|---|--|--|---|--|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EARNEST Edwin Runkles</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3-23-79</b>                       |   |  | 2b. HOUR<br><b>915 P M</b>   |   |  |                                       |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 20 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick Co.</b> MD.   |   |  |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Farmer</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Frederick</b>  |   | 13c. CITY OR TOWN<br><b>Mt. Airy</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Route 4</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>E. Wilfred Runkles</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha D. Summan</b> |   |  |  |   |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>218-36-3823</b>                           |   | 17. INFORMANT<br>ADDRESS<br><b>Ellen Bartol Runkles, Item 13</b>               |  |   |  |                                       |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Ca lung, recurrent</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |   |  |                                       |  |
| 19a. DATE OF OPERATION<br><b>1975</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ca lung</b>       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/21/79</b> , 19____, to <b>3/23/79</b> , 19____, that (I) (we) last saw the deceased alive on <b>3/23/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                    |  |   |  |   |  |  |   |  |                                       |  |
| 22b. SIGNATURE<br><b>Austin Pearre</b>  |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/24/79</b>   |                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Austin Pearre, Jr. M.D.</b>   |  |   | 22e. ADDRESS<br><b>804 Toll House Ave., Frederick, Md.</b>               |   |  |  |   |  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Mar. 27, 1979</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Prospect</b>                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Mt. Airy, Frederick, Md.</b>                   |  |                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Olin L. Molesworth, Damascus, Md.</b>  |  |   | 25. DATE REG'D BY REGISTRAR<br><b>MAR 28 1979</b>                        |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |                                       |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Director, FBI

U.S.A.

Mr. Tolson

Director

Director, FBI

Director

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson, Director, FBI

Mr. Tolson, Director, FBI

Mr. Tolson

Mr. Tolson, Director, FBI

Mr. Tolson, Director, FBI

Mr. Tolson, Director, FBI

Mr. Tolson, Director, FBI

Mr. Tolson

Mr. Tolson, Director, FBI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | REG. NO. 79-07024               |
|---|--|---|--|---|--|---|--|---|--|---------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ora Soper SCHNEIDER  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 26, 1979          |   | 2b. HOUR<br>M  |   |  |                                 |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 23, 1892  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. IF UNDER 24 HRS<br>HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.                                   |  |   |  |                                 |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Nursing Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>School System                          |  |                                 |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |   |  |                                 |
| 13a. STATE<br>Kentucky  |  | 13b. COUNTY<br>Jessamine  |  | 13c. CITY OR TOWN<br>Nicholasville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>217 Richmond Avenue                                  |  |                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ore Allen Soper   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Miller |   |  |   |  |                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>none   |  | 17. INFORMANT<br>ADDRESS<br>Hm. T. Soper, 505 Grant Place<br>Frederick, Maryland 21701          |  |   |  |                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>S. stroke</u><br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  |   |  |                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>coronary arteriosclerosis</u>   |  |   |  |   |  |   |  |   |  |                                 |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-24-1978</u> to <u>Mar 26, 1979</u> , that (I) (we) last saw the deceased alive on <u>3-23-1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |   |  |   |  |   |  |   |  |                                 |
| 22b. SIGNATURE<br><u>Thomas Soper, M.D.</u>   |  |   |  |   | 22c. DATE SIGNED<br>3-28-79                                    |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thomas Soper, M.D.                 |  |                                 |
| 22e. ADDRESS<br>Frederick, MD   |  |   |  |   |  |   |  |   |  |                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>March 30, 1979  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Maple Grove Cemetery     |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Nicholasville, Jessamine, Ky. |  |                                 |
| 24. FUNERAL DIRECTOR<br>Smith, Fadelley, Keeney, Basford Funeral Home<br>106 East Church Street, Frederick, Md. 21701   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 28 1979                   |   |  | 25b. REGISTRAR'S SIGNATURE<br>M. J. Brady                                   |  |                                 |

BP

12-05054

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |                     |   |   |  |  |  |  | REG. NO. 79-07025   |                                |  |
|---|--|---|---------------------|---|---|--|--|--|--|---|--------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |                     |   | 2a. DATE OF DEATH MONTH DAY YEAR                              |  |  |  |  | 2b. HOUR A M  |                                |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JAMES D. SHELTON  |  |   |                     |   | 3-2-79  |  |  |  |  | 9:30 A M  |                                |  |
| 3. SEX<br>Male  |  | 4. RACE<br>W  |                     | 5. DATE OF BIRTH MONTH DAY YEAR<br>5-27-98 <sup>AR</sup>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                                     |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD.                          |  |  |  |   |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Citizens Nursing Home |                     |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Farmer        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Farming                           |  |   |                                |  |
| 13a. STATE<br>Maryland  |  |   |                     |   | 13b. COUNTY<br>Fred.  |  | 13c. CITY OR TOWN<br>Emmitsburg  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>Route 2 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James William SHELTON  |  |   |                     |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Stella McKINNEY |  |  |  |  |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |   |                     |   | 16b. SOCIAL SECURITY NO.<br>202-20-6532                       |  | 17. INFORMANT ADDRESS<br>Mr. Charles W. Mumma (Friend),<br>Rocky Ridge, Maryland 21778 |  |  |   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Vertebral Artery Thrombosis</u><br><u>4332</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Generalized Arterio-sclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |                     |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 month</u>  |                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |                     |   |   |  |  |  |  |   |                                |  |
| 19a. DATE OF OPERATION  |  |   |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |                     | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |                                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 3</u> , 19 <u>78</u> , to <u>March 2</u> , 19 <u>79</u> , that (I) <u>must</u> lost saw the deceased alive on <u>March 2</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did not</u> view the body after death.                    |  |   |                     |   |   |  |  |  |  |   |                                |  |
| 22b. SIGNATURE<br><u>Bernard O. Thomas Jr. M.D.</u>   |  |   |                     |   |   | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br><u>3/2/79</u>                                      |  |   |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Bernard O. Thomas, Jr., M.D.   |  |   |                     |   |   | 22e. ADDRESS<br>N. Market St., Frederick, Md. 21701                            |  |  |  |   |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>3/5/79 |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Ch of the Brethren Cem  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Rocky Ridge, Frederick, Md. |  |   |                                |  |
| 24. FUNERAL DIRECTOR NAME<br>Charles Wm. Miller Funeral Home,<br>104 East Main Street, Thurk ont, Maryland  |  |   |                     |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1979                                    |  | 25b. REGISTRAR'S SIGNATURE<br><u>Barney McBrady</u>                    |  |   |                                |  |

BP \_\_\_\_\_

78-07052

For the purpose of this report, the following information was obtained from the records of the Department of the Interior, Bureau of Land Management, and the Bureau of Reclamation, and from the records of the various States and Territories in which the land is located. The information was obtained from the records of the Department of the Interior, Bureau of Land Management, and the Bureau of Reclamation, and from the records of the various States and Territories in which the land is located.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-07026

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |  |   |   |   |   |  |
|---|--|--|---|--|---|---|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Louis Alfred Simmons</b>  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>3 15 79</b>                     |  |   | 2b HOUR<br><b>6 58 AM</b>   |   |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 4 04</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD.</b>                 |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Presser</b>   |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Dry Cleaning</b>   |  |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Frederick</b>   |   | 13c CITY OR TOWN<br><b>Frederick</b>   |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET ADDRESS<br><b>334 W. Patrick Street</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William L. Simmons</b>  |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nettie Mathias</b>  |   |   |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>none</b>  |   | 17 INFORMANT ADDRESS<br><b>Mrs. Margaret Simmons, 334 W. Patrick Street, Frederick, Md. 21701</b>  |   |   |   |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAL ARREST</b><br><b>5715</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>LIVER FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CIRRHOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4-5</b> |  |  |   |  |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>METASTATIC CARCINOMA OF NECK</b>   |  |  |   |  |   |   |   |   |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>3/5</b> , 19 <b>79</b> , to <b>3/15</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/14</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |   |   |   |  |
| 22b SIGNATURE<br><i>[Signature]</i>   |  |  |   |  |   | DEGREE<br><b>D.O.</b>   |   | 22c DATE SIGNED<br><b>3/15/79</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Gerald Reed, M.D.</b>  |  |  |   |  |   | 22e ADDRESS<br><b>335 Park Avenue, Frederick, Md. 21701</b>                         |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  |  | 23b DATE<br><b>Mar 16, 1979</b>                                       |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory</b> |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, Pr. Geo's, Md.</b> |   |  |
| 24 FUNERAL DIRECTOR<br><i>[Signature]</i><br><b>Smith, Fadelley, Keeney, Bassford Funeral Home</b><br><b>106 East Church Street, Frederick, Md. 21701</b>   |  |  |   |  |   | 25a DATE REC'D. BY REGISTRAR<br><b>MAR 19 1979</b>                                  |   | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO. 79-07027   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) <b>Maurice Gaver SNYDER</b>  |  |   |  | 2a. DATE OF DEATH MONTH <b>3</b> DAY <b>30</b> YEAR <b>79</b>                    |  | 2b. HOUR <b>4:40 AM</b>   |  |   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH <b>May</b> DAY <b>5</b> YEAR <b>1902</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.                                   |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick Co., MD.</b>                   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Citizens Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stock Clerk</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Carroll</b>  |  | 13c. CITY OR TOWN <b>Mt. Airy</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS <b>Rt. 5, Box 37</b>                    |  |
| 14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>-</b> LAST <b>Snyder</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b>-</b> LAST <b>Garver</b>  |  |   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>577-05-3764</b>   |  | 17. INFORMANT ADDRESS <b>Blanche S. Snyder, Item 13</b>   |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis &amp; Meningitis</b>  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Weeks</b> |  |
| 5829 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Disease (Chronic)</b>  |  |   |  |   |  |  |  |   |  | 2 yrs.  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>  |  |   |  |   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sep 3/24</b> 19 <b>78</b> , to <b>March</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>3/31/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.) |  |   |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Robert L. Kaufmann, M.D.</b>  |  | DEGREE <b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED <b>3/31/79</b>  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert L. Kaufmann, M.D.</b>   |  | 22e. ADDRESS <b>804 Toll House Ave., Frederick, Md.</b>   |  |   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>Apr. 3, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Locust Grove</b>  |  | 23d. LOCATION CITY OR TOWN <b>Mt. Airy, Frederick, Md.</b>                       |  | COUNTY STATE  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Olin L. Molesworth, Damascus, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 4 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Pickney McCreedy</b>  |  |  |  |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 7/77  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |                             | REG. NO. 79-07028           |  |
|--|--|--|--|---|--|--|--|--|-----------------------------|-----------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Mary Jane SPALDING</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 7, 1979</b>                             |  |  | 2b. HOUR<br><b>10:40 AM</b> |                             |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 5 1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                                    |  | IF UNDER 1 YEAR MONTHS DAYS  |                             | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, Md.</b> MD.             |  |  |                             |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Jefferson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Jefferson, Md. (Dr. A.T. Brice)</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>- - - - -</b>  |                             |                             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN <b>Pt. of Rocks</b> 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>13e. STREET ADDRESS <b>Pt. of Rocks, Maryland</b>   |  |  |  |   |  |  |  |  |                             |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George F. Brown</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Annie V. Wright</b>  |  |  |  |  |                             |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>- - - - -</b>   |  | 17. MR. GEORGE F. STUCK, 309 S. Second Street, Oakland, Maryland 21550  |  |  |  |  |                             |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest - Coronary Occ.</b><br><b>410-</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Arteriosclerotic C.V. disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Obesity</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 mcs</b><br><b>5 yrs</b> |  |  |  |   |  |  |  |  |                             |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Obesity</b>  |  |  |  |   |  |  |  |  |                             |                             |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |                             |                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |                             |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> 19 <b>73</b> to <b>Mar 7</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Mar 7 19 79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |                             |                             |  |
| 22b. SIGNATURE <b>Dr. A. Talbott Brice</b>   |  |  |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>           |  |  |  | 22c. DATE SIGNED <b>3/9/79</b>   |                             |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. A. Talbott Brice, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>Jefferson, Maryland 21755</b>  |  |  |  |  |                             |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>March 10, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul's Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Pt. of Rocks Frederick Md.</b>         |  |  |                             |                             |  |
| 24. FUNERAL HOME<br><b>Smith Fadeloy Keeney Basford Funeral Home</b><br><b>106 East Church St., Frederick, Md. 21701</b>   |  |  |  |   |  |  |  |  |                             |                             |  |

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Jefferson

Jefferson, Mr. Dr. A. B. Jones

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Maryland - Frederick

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Frederick County, Maryland

George

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Brown

Annie

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Mr. George J. Jones, 300 S. Second  
Street, Oakland, Maryland 21220

Dr. A. B. Jones, 1972, Maryland 21220

March 10, 1972, Frederick, Md.

1972, Frederick, Md. 21701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | REG. NO. 79-07029                            |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Lillian Hypatia Speak  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3-21-79   |  | 2b. HOUR<br>2:40 P.M.                        |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 24 08  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS. HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>FREDERICK COUNTY MD.                                 |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>FREDERICK  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FREDERICK MEMORIAL HOSP. |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEKEEPER  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |   |  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>FREDERICK   |  | 13c. CITY OR TOWN<br>WOODSBORO  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>84 SECOND ST.  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>CHARLES W. HORNER  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SARAH ANDERS   |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>214-H-6452   |  | 17. INFORMANT ADDRESS<br>CHARLOTTE MASSER, WOODSBORO, MD  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>LIVER FAILURE</u><br>1579<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE CARCINOMA OF THE PANCREAS</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>21 FEB</u> 19 <u>79</u> to <u>21 MARCH</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>21 MARCH</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>George I. Smith, Jr.  |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED<br>21 MAR 79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE I SMITH, JR.  |  | 22e. ADDRESS<br>FREDERICK, MARYLAND  |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>3-24-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CAM HILL CEM.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>NEGROE MARYLAND                                   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>D. Hutzler   |  | ADDRESS<br>WOODSBORO, MARYLAND   |  | 25a. DATE RECEIVED BY REGISTRAR<br>MAR 27 1979  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DHMH - 16 50M 1/76  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | REG. NO. 79-07030   |  |  |
|---|--|---|--|---|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR                                       |  |  |  |  | 2b. HOUR P. M.  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>RUTH AVICE THOMAS   |  |   |  |   | March 27, 1979   |  |  |  |  | 5:15 P. M.  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept. 28, 1885   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS                                      |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 7. IF UNDER 24 HRS. HOURS MIN.                            |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick Co. MD.                      |  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Braddock Hgts.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Vindabona Nursing Home |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>secretary     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>private   |  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |   |  |   | 13b. COUNTY<br>Frederick   |  | 13c. CITY OR TOWN<br>Middletown  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   | 13e. STREET ADDRESS<br>10 Linden Blvd. |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>CALVIN A. THOMAS   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ALICE BUXTON             |  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>225-09-9757 |  | 17. INFORMANT ADDRESS<br>Mrs. Ruth Gardner Middletown, Md. 21769                     |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>2639<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Starvation - (refused to eat or drink)</u><br>(c) <u>1 month</u>                   |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Immediate |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION<br>3/7/79  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>④ femoral artery & vein embolization |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                               |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |   |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>4/21</u> , 19 <u>77</u> , to <u>3/27</u> , 19 <u>79</u> , that (b) (we) lost saw the deceased alive on <u>3/24</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |  |   |  |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br>W. H. Hager   |  |   |  |   | DEGREE<br>MD   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/28/79                               |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Wayne Allgaier   |  |   |  |   | 22e. ADDRESS<br>Brunswick, Md.   |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>Mar. 30, 1979   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cem.                  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick Fred. Md.  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Gladhill Co. Middletown, Md.  |  |   |  |   | ADDRESS<br>21769   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 2 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |   |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 79-07031  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |  |  |
| EDNA M. UMBERGER   |  |  |  | March 31 1979  |  | 10 p/m  |  |  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. UNDER 1 YEAR 8. UNDER 24 HRS              |  |
| Female   |  | White  |  | August 7, 1901   |  | 77  |  | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| Maryland   |  | U. S. A.   |  |  |  | Frederick   |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Frederick  |  | Frederick Nursing Center   |  | Homemaker  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS                          |  |
| Maryland   |  | Frederick  |  | Route 10   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | Route 10, Frederick, Maryland                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO   |  | 17. INFORMANT ADDRESS                        |  |
| George Edward Cook   |  | Elmira Lucinda Stockman  |  | No   |  | 219 36 2521 B   |  | Edward L. Umberger, Route 10, Frederick, Md. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>  |  | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u>                                     |  | DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| 4280   |  |  |  |  |  | 5 days  |  | 3 mos.                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Jan 2, 1979</u> to <u>March 31, 1979</u> and that (2) (we) last saw the deceased alive on <u>3/30/79</u> and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) did not view the body after death. |  | 22b. SIGNATURE DEGREE  |  | 22c. DATE SIGNED   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>          |  |   |  |  |  |
| Robert L. Kaufmann, M.D.   |  | 804 Toll House Ave., Frederick, Maryland   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |
| Burial   |  | April 4, 1979  |  | Mt. Olivet Cemetery  |  | Frederick Frederick Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| Smith, Fideley, Kenney & Bassford Funeral Home   |  | APR 6 1979   |  | Fideley, Kenney & Bassford   |  |   |  |  |  |
| 106 East Church Street, Frederick, Maryland  |  |  |  |  |  |   |  |  |  |

15070-0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, the physician must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 1/76  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 79-07032   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Fannie Mae Van Acore  |  |   |  | 2b. HOUR 11 35 PM   |  |   |  |
| 3. SEX Female  |  | 4. RACE Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 25, 1894  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Frederick, MD.   |  |
| 10. CITY OR TOWN OF DEATH Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY None  |  |
| 13a. STATE Maryland  |  |   |  | 13b. CITY OR TOWN Frederick   |  | 13c. CITY OR TOWN Frederick   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles E. O'Haro   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Fannie Esworthy   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |   |  | 16b. SOCIAL SECURITY NO. xxxxxxxxxx   |  | 17. INFORMANT ADDRESS<br>Miss Caroline E. VanAcore Frederick, Md.   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Acute myocardial infarction<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Acute stenosis |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from 3/26/79, 19 to 3/28/79, 19, that (I) (we) last saw the deceased alive on 3/28/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE A. Austin Pearre, Jr. M.D.  |  |   |  | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>      |  | 22c. DATE SIGNED 3/28/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Austin Pearre, Jr. M.D.   |  |   |  | 22e. ADDRESS Toll House Avenue Frederick, Md. 21701   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 3-31-1979   |  | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.   |  |
| 24. FUNERAL DIRECTOR NAME Robert E. Daily & Son  |  |   |  | ADDRESS 1201 N. Market Frederick, 176   |  | 25a. DATE REC'D. BY REGISTRAR APR 3 1979  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |

18-01035

Robert Smith & Son  
Frederick, Md.  
1891

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |                              |   |  |  |  | REG. NO. 79-07033                |  |
|---|--|--|--|---|------------------------------|---|--|--|--|----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Helena Gertrude Wilhide   |  |  |  |   | 2a. DATE OF DEATH<br>3/31/79 |   |  | 2b. HOUR<br>4:20 AM  |  |                                  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Female  |  | 5. DATE OF BIRTH<br>Jan. 26, 1890   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 74 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.                                   |  |  |  |                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Mem. Hospital |  |   |                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bookkeeper                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Ice Cream Co.   |  |                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Frederick   |  | 13c. CITY OR TOWN<br>Frederick  |                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>258 Dill Avenue   |  |                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jesse Haines  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary E. Ramsburg   |                              |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |                                  |  |
| 16b. SOCIAL SECURITY NO.<br>none  |  |  |  | 17. INFORMANT<br>Mrs. Larry Wenschhof, Frederick, Md.   |                              |   |  | 18. ADDRESS<br>258 Dill Avenue   |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 586- Cerebral vessel rupture<br>(b) Chronic<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>9 days<br>9 days |  |  |  |   |                              |   |  |  |  |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |                              |   |  |  |  |                                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                              |   |  |  |  |                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |   |  |  |  |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/22 1979, to 3/31 1979, that (I) (we) last saw the deceased alive on 3/30 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                              |   |  |  |  |                                  |  |
| 22b. SIGNATURE<br>Robert S. Hughes  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                              |   |  | 22c. DATE SIGNED<br>3/31/79  |  |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Robert S. Hughes, M.D.   |  |  |  | 22e. ADDRESS<br>700 Montclair Ave., Frederick, Md.  |                              |   |  |  |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Apr 3, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Olivet Cem.   |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Md.                         |  |  |  |                                  |  |
| 24. FUNERAL DIRECTOR<br>Smith, F. Adeley, Keeney, Basford Funeral Home  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 6 1979   |                              |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |                                  |  |
| 106 East Church St., Frederick, Md.   |  |  |  |   |                              |   |  |  |  |                                  |  |

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

19-01033



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |   | 79-07034   |  |
|--|--|--|--|---|---|---|--|--|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO.   |   |   |   |  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGARET JANE WILLHIDE</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 17 79</b>                  |   |   | 2b. HOUR<br><b>2:40 PM</b>  |  |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 18, 1917</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 8. IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick, Co.</b> MD.                               |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Claire Frock</b>                     |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Frederick</b>  |  | 13c. CITY OR TOWN<br><b>Thurmont</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>13 N. Carroll St.</b>                              |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Tilden Miller</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Levina Tressler</b>   |   |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-28-6856</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Richard S. Willhide 13 N. Carroll St.</b>  |   |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 hours</b><br><b>years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 3 17 79</b> |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>504 Toll House Ave. Frederick, Md.</b>  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/17/79</b> to <b>3/17/79</b> , that (I) (we) last saw the deceased alive on <b>3/17/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>P. E. Cline II, MD</b>  |  |  |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3/17/79</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Casper E. Cline II</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>504 Toll House Ave. Frederick, Md.</b>                                       |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>March 20, 1979</b>                                     |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Blue Ridge</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Thurmont, Frederick Md.</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Stiles Funeral Home</b>   |  |  |  |   |   | ADDRESS<br><b>210 W. Main St. Emmitsburg, Md. 21727</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1979</b>                          |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patrick K. Brady</b>                          |  |

BP

9-01034